한국어 (Korean):	참조: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 도구 및 서비스도 무료로 제공해 드립니다. 자세한 정보는 플랜에 전화하거나 서비스 제공업체에 문의하십시오.
Русский (Russian):	ВНИМАНИЕ: Если вам удобнее для общения русский язык, вы можете воспользоваться бесплатными услугами языковой поддержки. Также доступны необходимые вспомогательные средства и услуги предоставления информации в доступном формате для людей с ограниченными возможностями. Для получения дополнительной информации позвоните или обратитесь к своему поставщику.
اللغة العربية (Arabic):	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالخطة للحصول على مزيد من المعلومات أو للتحدث مع مقدم الخدمة الذي تتعامل معه.
हिंदी (Hindi):	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। प्लान के बारे में अधिक जानकारी के लिए कॉल करें या अपने प्रदाता से बात करें।
Italiano (Italian):	ATTENZIONE: Se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiami il numero corrispondente al Suo piano per ulteriori informazioni o si rivolga al Suo fornitore.
Português (Portuguese):	ATENÇÃO: Se fala português, tem à sua disposição serviços gratuitos de assistência linguística. Também estão disponíveis equipamentos e serviços de assistência adequados que lhe permitem ter acesso às informações em formatos acessíveis, de forma gratuita. Contacte o plano para obter mais informações ou fale com o seu prestador.
Kreyòl Ayisyen (Haitian Creole):	ATANSYON: Si ou pale kreyòl ayisyen, w ap jwenn sèvis asistans lengwistik gratis. Gen èd ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma ki aksesib, ki disponib gratis tou. Rele plan an pou jwenn plis enfòmasyon oswa pou w pale ak pwofesyonèl swen sante w la.
Polski (Polish):	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie wsparcie i usługi pomocnicze w celu zapewnienia informacji w przystępnych formatach są również dostępne bezpłatnie. Dodatkowe informacje można uzyskać dzwoniąc do planu lub rozmawiając ze świadczeniodawcą.
日本語 (Japanese):	注：お客様が[日本語]を話す場合は、無料の言語アシスタンス・サービスを利用できます。アクセスしやすい形式で情報提供を行うための、適切な補助器具やサービスも無料でご利用いただけます。詳細はプランにお電話いただくか、プロバイダーにご相談ください。

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English:	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the plan for more information or speak to your provider.
Español (Spanish):	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También puede solicitar, sin costo alguno, servicios o herramientas especiales para acceder a la información en formatos accesibles. Llame al plan para obtener más información o hable con su proveedor.
中文 (Chinese Mandarin):	注意：如果您说中文，我们可以为您免费提供语言协助服务。我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电计划以获取更多信息或与您的服务提供者联系。
中文 (Chinese Cantonese):	注意：如果您說中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電本計劃查詢更多資訊或諮詢您的醫療服務提供者。
Tagalog (Tagalog):	PAGBIGAY-PANSIN: Kung nagsasalita ka ng wikang tagalog, available para sa iyo ang mga serbisyo ng libreng tulong sa wika. Available din nang walang bayad ang mga wastong dagdag na tulong at serbisyo na makapagbibigay-impormasyon sa mga naa-access na format. Balikan ang plano para sa higit pang impormasyon o makipag-usap sa iyong provider.
Français (French):	ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits peuvent être mis à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez votre régime d'assurance maladie pour obtenir des informations supplémentaires, ou adressez-vous à votre prestataire.
Việt (Vietnamese):	CHÚ Ý: Nếu quý vị nói tiếng việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Hãy gọi cho chương trình để biết thêm thông tin hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.
Deutsch (German):	BITTE BEACHTEN: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Hilfsdienstleistungen zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Für weitere Informationen wenden Sie sich bitte an den Kundendienst Ihrer Versicherung bzw. an Ihren Versicherungsberater.

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at 42 CFR 405.910.

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: https://www.hhs.gov/sites/default/files/OMHA-118.pdf

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

1355-07-07-0000048-0005-0000301

Form CMS-1696 Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

1355-07-07-0000048-0005-0000301

Medicare Appeal #:_____
(For C2C use only)

If you don't know if your prescription drug coverage was creditable:

To help your case, you may want to send a letter to your previous plan and ask if your coverage was creditable. Attach your letter and any response to this form. You shouldn't wait to receive a response before you send this request form, and there is no need to send a letter if your prior coverage was with a Medicare Part D plan.

☐ I believe the LEP is wrong because I was not eligible to enroll in a Medicare Part D plan during the period stated by my current Medicare Part D plan. Example: You lived outside of the United States during the initial enrollment period stated by your Medicare Part D plan. You must submit proof why you believe the LEP is wrong, such as proof of overseas residency.

☐ I believe the LEP is wrong because I was unable to enroll in a Medicare Part D plan due to a serious medical emergency. You must submit proof that you experienced a serious medical emergency (e.g. unexpected hospitalization) that affected your ability to timely enroll in a Medicare Part D plan.

☐ I have/had Extra Help from Medicare to pay for my prescription drug coverage.
- Dates of Extra Help: from_____to _____
- Use a separate sheet if necessary.

By signing this form, I give permission to any entity to release information needed by Medicare or its independent contractor (C2C Innovative Solutions Inc.) to review my Medicare Part D late enrollment penalty appeal.

I certify that the information on this form is true, accurate and complete. I understand that if I have submitted any false documents, made any false claims or statements, or concealed any material facts, I may be subject to civil or criminal liability.

_____ _____
Signature of Enrollee Date

- Be sure to include your Medicare Health Insurance Claim number or Medicare Beneficiary Identifier on any materials you send.
- Do not send original documents.
- Please make sure the enrollee and representative, if applicable, have signed this form.

Send this form and any extra pages to:

Standard Mail:
C2C Innovative Solutions, Inc.
Part D LEP Reconsiderations
P.O. Box 44165
Jacksonville, FL 32231-4165

Courier or Tracked Mail:
C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 600
Jacksonville, FL 32202

Toll Free fax for enrollees:
(833) 946-1912

Web Portal Address:
https://www.c2cinc.com//Appellant-Signup

Note about Representatives:
If you want another individual, such as a family member, friend, or your doctor to request a reconsideration for you, that individual must be your representative.

Complete the attached Appointment of Representative form only if you wish to have another individual represent you for this appeal.

Medicare Appeal #:_____
(For C2C use only)

Part D Late Enrollment Penalty (LEP) Reconsideration Request Form

Please use one (1) Reconsideration Request Form for each Enrollee.

Date:_____

Enrollee Name:_____ _____
First Name Last Name

Address:_____City: _____

State:_____Zip Code: _____

Phone: (_____) _____

Medicare Number: _____

Date of Birth (MM/DD/YYYY): _____

Name of current Part D Drug Plan:_____

IMPORTANT: A signature by the enrollee is required on this form in order to process an appeal. Complete, sign and mail this request to the address at the end of this form, or fax it to the number listed on this form within 60 days from the date on the letter you received stating you have to pay a late enrollment penalty. If it has been more than 60 days, explain your reason for delay on a separate sheet and send it with this form.

Check all boxes that apply to you:

☐ I had other prescription drug coverage as good as Medicare's (creditable coverage). Please provide evidence of prior creditable prescription drug coverage. For example:

- If you had drug coverage from an employer or union plan, provide a copy of the Notice of Creditable Prescription Drug Coverage or Certificate of Prior Creditable Prescription Drug Coverage from the employer or union plan.
- If you had/have drug coverage with the Department of Veterans Affairs (VA), please provide any of the following: Notice of Creditable Prescription Drug Coverage; a copy of your VA Health Benefit Card; a letter from the VA certifying eligibility; or an Explanation of Benefits (EOB).
- If you have drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization (I/T/U), please provide a copy of any of the following: IHS registration card; letter verifying eligibility and/or enrollment.

Name of former employer/union/other insurer: _____

Dates of coverage (MM/DD/YYYY) from_____to_____

Plan Address & Phone:_____

Contact Name:_____Phone:_____

☐ I had prescription drug coverage but I didn't get a notice that clearly explained if my drug coverage was creditable coverage.

Reminder: Most non-Medicare plans that offer prescription drug coverage, like employer or union coverage, must send enrollees a notice explaining how their prescription drug coverage compares to Medicare prescription drug coverage. Plans may provide this information in their benefits handbook or as a separate written notice.

1355-07-07-0000048-0004-0000300

Medicare Prescription
Drug Plans

HealthSpring℠

Part D Late Enrollment Penalty Reconsideration Notice

YOUR RIGHT TO ASK MEDICARE TO REVIEW YOUR MEDICARE PART D LATE ENROLLMENT PENALTY

"Creditable prescription drug coverage" is coverage (for example from an employer or union) that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If you don't join a Medicare drug plan when you are first eligible, and you don't have other "creditable prescription drug coverage," you may have to pay a late enrollment penalty (LEP).

What if I Don't Agree with Medicare's Late Enrollment Penalty Decision?
In some cases you have the right to ask Medicare to review your late enrollment penalty decision. This is called a "reconsideration." For example, you could request a reconsideration if you think Medicare did not count all of your creditable coverage or if you didn't get a notice that explained whether your previous prescription drug coverage was creditable. Other reasons for requesting a reconsideration are listed on the request form sent with this notice.

Who Can Ask for a Reconsideration?
You or someone you name to act for you (your representative) can ask for a reconsideration. If someone requests a reconsideration for you, he or she must send proof of his or her right to represent you with the request form. Proof could be a power of attorney form, a court order, or an "Appointment of Representative" form. This last form can be found at https://www.medicare.gov/forms-help-resources/medicare-forms. You also can call the Medicare helpline (see below) and ask for Form CMS-1696.

How Do I Ask for a Reconsideration?
Complete the reconsideration request form sent with this notice. Mail it to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you had to pay a late enrollment penalty. You should also send any proof that supports your case, like information about previous creditable prescription drug coverage. If you wait more than 60 days, you must explain why your request is late. Medicare will decide if you had good cause to send a late request.

What Do I Need to Include with My LEP Reconsideration Request?
1. A completed, signed LEP reconsideration request (keep a copy).
2. Copies of information you believe may help your case.
3. If you've named someone to act for you, a copy of the proof the individual can represent you.

NOTE: Do not send original documents.

Where Can I Get More Information?
Call HealthSpring at 1-800-222-6700 7 days a week, 8 a.m. - 8 p.m., local time. Our automated phone system may answer your call during weekends from April 1 - September 30. TTY users should call the plan at 711.

Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for help, 24 hours a day, 7 days a week. TTY users should call Medicare at 1-877-486-2048.

- You had other prescription drug coverage (such as through an employer, union, or another plan) during the time we show a gap.
- You were covered by Veterans Affairs (VA), TRICARE, or Indian Health Service during that time.
- You had drug coverage, but it was not reported correctly to us.
- You believe the dates of your coverage gap are incorrect.

Please follow the steps in the letter attached to request reconsideration.

What if I have more questions?
Call us at 1-800-222-6700, 7 days a week, 8 a.m. - 8 p.m., local time. Our automated phone system may answer your call during weekends from April 1 - September 30. TTY users should call 711.

Frequently Asked Questions

Why did I receive this letter?

Our records show there was a time when went 63 days or more without prescription drug coverage. When this happens, Medicare requires a Late Enrollment Penalty (LEP). This penalty is added to your monthly premium.

What is the Late Enrollment Penalty (LEP)?

The LEP is an extra cost you pay each month with your drug plan premium if you had a gap in coverage of 63 or more days after you first became eligible for Medicare Part D.

How is the LEP calculated?

The LEP is 1% of the national average monthly drug plan for each month you went without coverage.

For example: If the national average premium is $38.99, and you went 14 months without coverage:

- 14% of $38.99 = $5.49
- The penalty is rounded to the nearest $0.10, so the penalty would be $5.50 additional each month
- In this example, $5.50 would be added to your monthly plan premium

What if I cannot afford the LEP?

If you qualify for Extra Help or Medicaid, it could lower your costs and remove the penalty. To apply:

- Call The Social Security Administration at 1-800-772-1213, between 8 a.m. to 7 p.m., Monday through Friday. TTY users, call 1-800-325-0778
- You can also contact your State Medicaid Office at 1-800-252-8263

Are there other ways to lower costs?

Yes. During the Annual Enrollment Period, from October 15 - December 7, you can look for a more affordable plan. Generally, you cannot switch plans outside of the annual enrollment period unless you have a Special Enrollment Period (SEP). If you're not sure if you have a SEP, please contact customer service for assistance.

Note: If you choose to join another Medicare Part D plan, you'll still pay the penalty with the new plan, even if the plan offers a $0 monthly plan premium.

What if I disagree with the LEP?

If you think the penalty was added by mistake, you can ask for it to be reviewed. This is called a reconsideration request.

You might disagree with the LEP if, for example: