

## **MEDICARE D – PRESCRIPTION DRUG FINAL RULE (Eff. Date 1/1/2006)**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 and its implementing regulations contained a requirement that plan sponsors disclose the status of their plan as creditable coverage to CMS in a manner and form to be specified at a future date. On December 30, 2005, CMS published additional guidance defining the form and manner in which disclosure is to be provided to CMS.

### **OBLIGATION TO PROVIDE NOTICE TO CMS OF PLAN STATUS AS CREDITABLE COVERAGE TO MEDICARE D**

Each entity that offers prescription drug coverage is required to complete an online form to notify CMS if the plan is creditable to Medicare D. The form can be accessed by selecting Disclosure to CMS Form under the Guidance Documents at [www.cms.hhs.gov/creditablecoverage](http://www.cms.hhs.gov/creditablecoverage).

Electronic notification is the only option for complying with the notice requirement and notice must be provided to CMS as follows:

- By March 31, 2006 for current plan years that end in 2006
- Annually within 60 days of the start of a new plan year
- Within 30 days after the termination of a plan
- Within 30 days after any change in the plan's status as creditable coverage under Part D

The following information will be needed to complete the online form:

- Employer name
- Employer tax identification number (TIN/EIN)
- Address
- Phone number
- Type of coverage (e.g. group health plan)
- Number of plan options offered
- Creditable status of each plan option. After entering the answer, the following additional questions will be shown on the form:
  - Beginning and ending dates of the plan year for which notice is being provided
  - Estimate of the number of Part D eligible individuals the plan covers
  - Estimate of the number of Part D eligible individuals that are covered as retirees
  - Date the employer provided creditable coverage notices to Part D eligible individuals under the plan,
  - Whether this is a change to previously submitted information
- Name, title and e-mail address of the individual completing the form
- Date you are completing the form

A copy of the online form is attached for your reference while completing it online.

## Creditable Coverage Disclosure to CMS Website

Complete the following information for each Type of Coverage offered by the Entity/Plan Sponsor:

Name of Entity Offering Coverage	<input type="text"/>
Entity Federal ID Number	<input type="text"/> ex: XX-XXXXXXXX
Street Address of Entity	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>
Phone Number of Entity	<input type="text"/> ex: XXX-XXX-XXXX
Type of Coverage (Choose One):	
GROUP HEALTH PLAN:	
<input type="radio"/> Employer Sponsored Plan	
<input type="radio"/> Union/Taft Hartley Sponsored Plan	
<input type="radio"/> Church	
<input type="radio"/> Federal Government	
<input type="radio"/> State Government	
<input type="radio"/> Local Government	
<input type="radio"/> Other Entity	
STATE-SPONSORED PLANS:	
<input type="radio"/> Medicaid	
<input type="radio"/> State Pharmacy Assistance Program (SPAP)	
<input type="radio"/> State High Risk Pool	
<input type="radio"/> Other State-Sponsored Plan: <input type="text"/>	
MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205):	
<input type="radio"/> Standardized Plan (H, I, J)	
<input type="radio"/> Pre-standardized Plan	
<input type="radio"/> Waiver State Plan	
<input type="radio"/> Innovative Benefit Rider	
<input type="radio"/> INDIVIDUAL HEALTH INSURANCE (Non-Medigap Plans)	
<input type="radio"/> VETERANS COVERAGE (under Chapter 55 of Title 10, U.S.C., including TRICARE)	
<input type="radio"/> MILITARY COVERAGE	
<input type="radio"/> INDIAN HEALTH SERVICE	
<input type="radio"/> TRIBE OR TRIBAL ORGANIZATION	
<input type="radio"/> URBAN INDIAN ORGANIZATION	
<input type="radio"/> OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS	
Please Fill in Type of Plan: <input type="text"/>	

How many Prescription Drug Options offered under this Coverage?

Please Select **One** of the following and an additional box will appear for you to complete the required disclosure information.

- All Options Offered Are Creditable.
- All Options Offered Are Non-Creditable.
- There are some Creditable or Non-Creditable Options Offered.

I understand and agree to the following statements:

- That this submission supersedes any previous submission of this information with dates prior to the date below;
- That the entity/plan sponsor agrees to disclose to CMS and all Medicare Part D eligible individuals any changes that would affect the creditable status of the above coverage as outlined under §423.56.
- That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
- That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

<input type="text"/>	<input type="text"/>
(Name of Entity's Authorized Individual)	(Title)
<input type="text"/>	<input type="text"/>
(Email of Entity's Authorized Individual)	Date (MM/DD/YYYY)
<input type="button" value="Submit the form"/>	<input type="button" value="Clear All Fields"/>