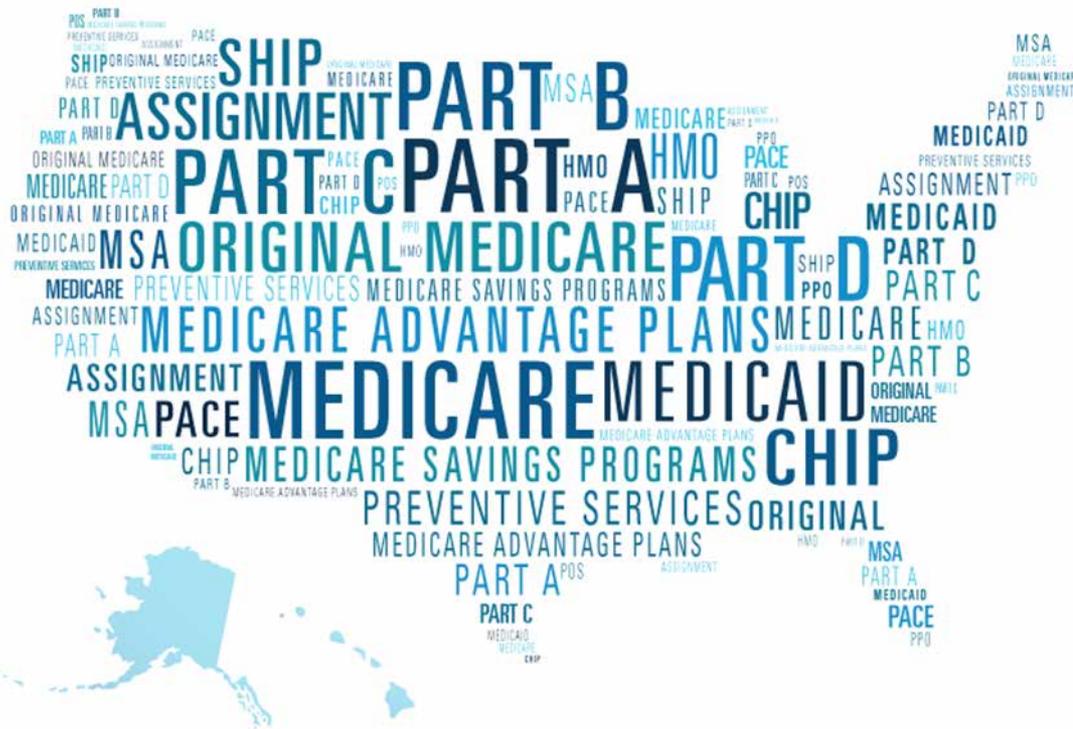


National Training Program

Module 2

Medicare Rights and Protections





Session Objectives

§ This session will help you

- Explain Medicare rights and protections
- Explain rights in certain health care settings
- Summarize Medicare privacy practices
- Locate additional information and resources



Lesson 1 — Medicare Rights

§ Guaranteed rights for everyone with Medicare

- Specific rights in
 - A. Original Medicare
 - B. Medicare Advantage and other Medicare health plans
 - C. Medicare Prescription Drug Plans

§ In general, these rights

- Protect you when you get health care
- Protect you against unethical practices
- Make sure you get medically-necessary services
- Protect your privacy



Your Medicare Rights

- § Be treated with dignity and respect
- § Be protected from discrimination
 - Race, color, national origin
 - Disability
 - Age
 - Religion
 - Sex
- § If you think you haven't been treated fairly
 - Visit hhs.gov/ocr
 - Call the Office for Civil Rights at 1-800-368-1019
 - ◻ TTY users should call 1-800-537-7697



Medicare and Your Information Rights

- § Have personal and health information kept private
- § Get information in a way you understand from
 - Medicare
 - Health care providers
 - Contractors (under certain circumstances)



Medicare Rights — Available Help

§ Get information to help you make decisions

- What is covered
- What Medicare pays
- How much you have to pay
- What to do to file a complaint or an appeal

§ Have questions about Medicare answered

- Call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048
- Call your State Health Insurance Assistance Program



Medicare Rights and Access to Care

- § Have access to doctors, specialists, hospitals
- § Learn about your treatment choices
 - In clear language
 - Participate in treatment decisions
- § Health care services
 - In a language you understand
 - In a culturally-sensitive way
- § Emergency care when and where you need it
 - If your health is in danger, and emergency help is needed, call 911



Medicare Rights — Claims and Appeals

- § Have a claim for payment filed with Medicare
- § Get decisions about
 - Health care payment
 - Coverage of services
 - Prescription drug coverage
- § Get an appeal (review) of the decisions above



Medicare Grievance Rights

- § File complaints (also called grievances)
- Including complaints about the quality of care
 - ◻ In Original Medicare, call the Quality Improvement Organization (QIO)
 - ◻ In Medicare Advantage or other Medicare plan, call your plan, the QIO, or both



Check Your Knowledge – Question 1

All people with Medicare have the right to be protected from discrimination based on race, color, national origin, disability, age, sex and which of the following?

a. Religion

b. Where they live

c. Their language



Check Your Knowledge – Question 2

An appeal and a grievance are the same thing.

a. True

b. False



A. Your Rights in Original Medicare

- § See any Medicare participating doctor or specialist
- § Go to any Medicare-certified hospital
- § Get information when Medicare isn't expected to pay or doesn't pay
 - Notices
 - Appeal rights



Medigap Rights in Original Medicare

§ Buy a private Medicare Supplement Insurance (Medigap) policy

- Guaranteed issue rights in your Medigap Open Enrollment Period where insurance company
 - q Can't deny you Medigap coverage
 - q Can't place conditions on coverage
 - q Must cover preexisting conditions
 - q Can't charge more because of past or present health problems
- Some states give additional rights



Appeal Rights in Original Medicare

§ File an appeal if

- A service or item isn't covered
 - And you think it should have been
- Payment for a service or item is denied
 - And you think Medicare should have paid for it
- You question the amount Medicare paid for a service



How to Appeal in Original Medicare

§ Medicare Summary Notice will tell you

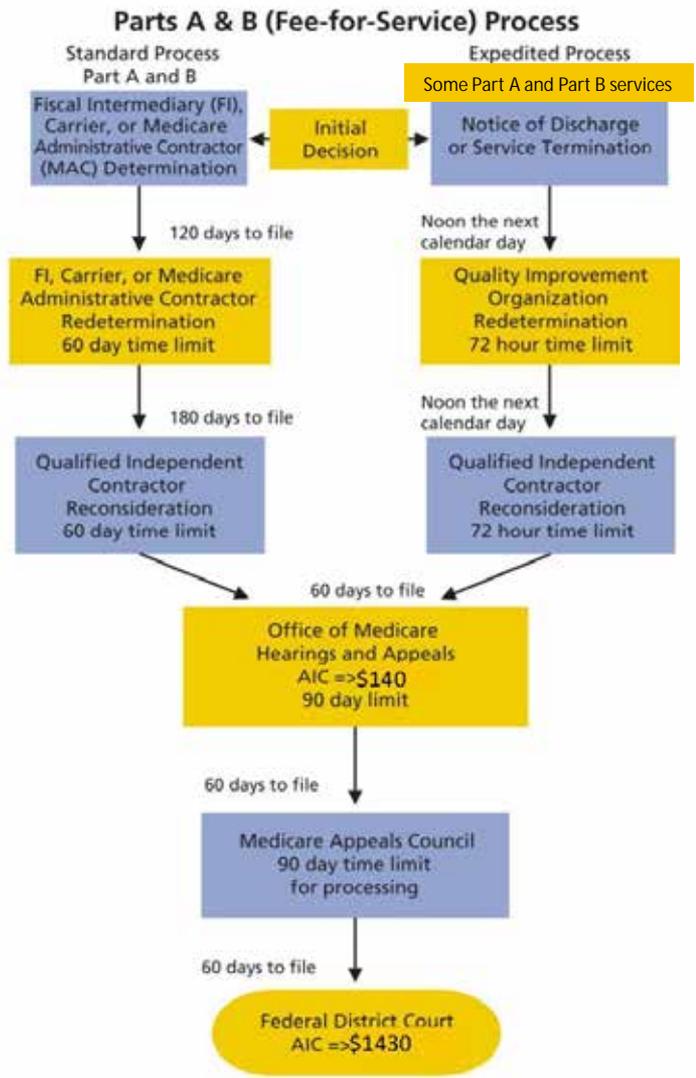
- Why Medicare didn't pay
- How to appeal
- Where to file your appeal
- How long you have to appeal

§ Collect information that may help your case

§ Keep a copy of everything you send to Medicare

Original Medicare Appeals Process

- Initial Decision
- Redetermination by Medicare → First Level of Appeal
- Reconsideration by Qualified Independent Contractor → Second Level of Appeal
- Hearing with Administrative Law Judge → Third Level of Appeal
- Review by Medicare Appeals Council → Fourth Level of Appeal
- Review by Federal District Court → Final Appeal Level



AIC = Amount in Controversy MA-PD = Medicare Advantage Prescription Drug A: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge MMA = Medicare Prescription Drug, B: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2014 AIC amounts. Contractor = Fiscal Intermediary, Carrier or Improvement & Modernization Act of 2003 C: A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Medicare Administrative Contractor (MAC) PDP = Prescription Drug Plan or the enrollee's physician. The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins IRE = Independent Review Entity QIC = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement.



Fast Appeals in Original Medicare

- § Ask your provider for information related to your case
- § Call the Quality Improvement Organization
 - To request a fast [expedited] appeal
 - No later than listed on the notice
- § If you miss the deadline
 - You still have appeal rights



Types of Liability Notices for People With Original Medicare

- § Advance Beneficiary Notice of Non-coverage
- § Skilled Nursing Facility Advance Beneficiary Notice
- § Hospital Issued Notice of Non-coverage



Original Medicare Protection From Unexpected Bills

- § Advance Beneficiary Notice of Non-coverage
- Given by health care provider or supplier
 - q Says Medicare probably won't pay for an item or service
 - q Not required for items or services excluded under law
 - q Will ask you to choose whether to get services
 - q Will ask you to confirm you read/understood notice



Check Your Knowledge – Question 3

The Advance Beneficiary Notice of Non-coverage is required to be used by all providers for all non-covered Original Medicare services.

a. True

b. False



B. Your Rights in Medicare Health Plans

- § To choose health care providers within the plan
- § To get a treatment plan from your doctor
 - For complex or serious conditions
 - Directly see specialists as often as necessary



Coverage and Appeal Rights in Medicare Health Plans

- § To know how your doctors are paid
- § To get a coverage decision or coverage information
- § A fair, efficient, and timely appeals process
 - Five levels of appeal
 - Decision letter sent explaining further appeal rights
 - Automatic review of plan reconsideration
 - By Independent Review Entity
- § To file a grievance about concerns or problems

Medicare Part C Appeals Process



Initial Determination

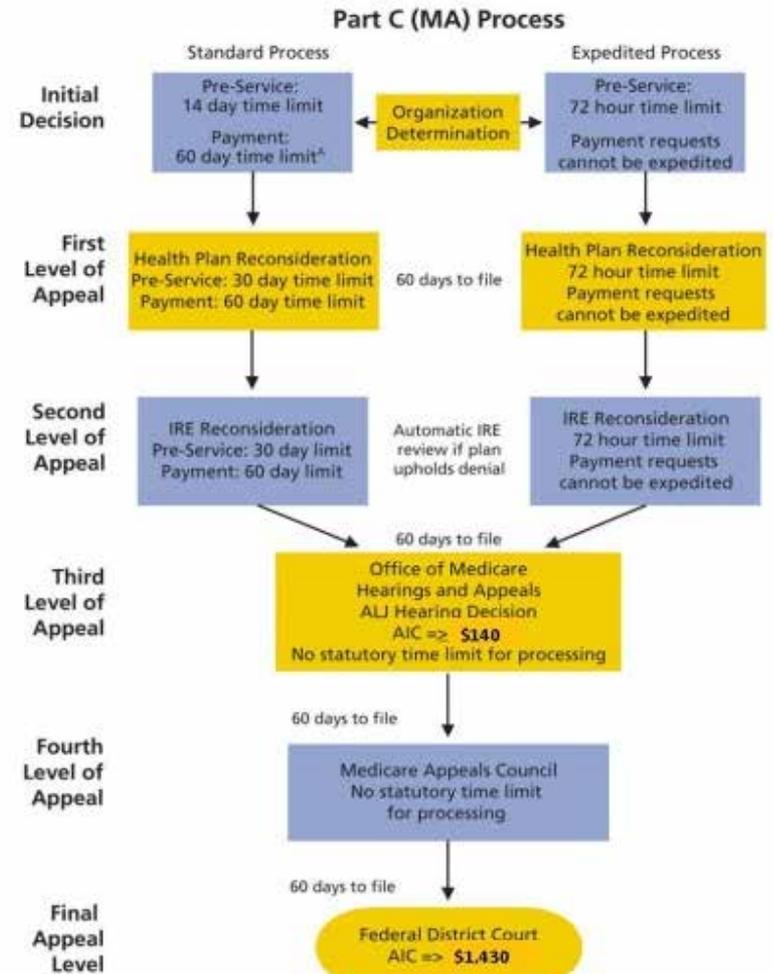
Plan Reconsideration →

Independent Review Entity (IRE) →

Administrative Law Judge (ALJ) →

Medicare Appeals Council (MAC) →

Judicial Review →



*These pre-service time frames include a possible extension of up to 14 days.

AIC = Amount in Controversy MA-PD = Medicare Advantage Prescription Drug A: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge MMA = Medicare Prescription Drug, B: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2014 AIC amounts. Contractor = Fiscal Intermediary, Carrier or Improvement & Modernization Act of 2003 C: A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Medicare Administrative Contractor (MAC) PDP – Prescription Drug Plan or the enrollee's physician. The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins IRE = Independent Review Entity QIC = Qualified Independent Contractor when the plan sponsor receives the physician's supporting statement.



Rights When Filing Medicare Health Plan Appeals

§ Right to access your case file

- Call or write your plan
- Plan may charge you a reasonable fee for
 - ◻ Copying
 - ◻ Mailing

§ Right to present evidence to support your case

§ Right to expedited appeal

- When supported by a doctor



Check Your Knowledge – Question 4

If you join a Medicare Advantage Plan, you have fewer rights than in Original Medicare when making an appeal.

a. True

b. False



C. Medicare Prescription Drug Coverage (Part D) Rights — Access to Covered Drugs

- § Must ensure enrollees can get drugs they need
- § Must include more than one drug in each classification
- § Must pay for brand-name as well as generic drugs
- § May have rules for managing access



Required Coverage — Part D

§ Medicare drug plans must cover all drugs in six protected categories

- Cancer medications
- Human immunodeficiency virus infection/acquired immunodeficiency syndrome (*HIV/AIDS*) treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments
- Immunosuppressants

§ All commercially available vaccines

- Except those covered under Part B (e.g., flu shot)



Formulary

§ A list of prescription drugs covered by the plan

§ May have tiers that cost different amounts

Tier Structure Example

Tier	You Pay	Prescription Drugs Covered
1	Lowest copayment	Most generics
2	Medium copayment	Preferred, brand name
3	High copayment	Non-preferred, brand name
Specialty	Highest copayment or coinsurance	Unique, very high cost



Transition Supply — Part D

§ Plans must fill prescriptions not on plan's formulary

- For new enrollees
- For residents of long-term care facilities

§ Immediate supply provided to new enrollee

- Fill one-time, 30-day supply of current prescription

§ While using transition supply

- Work with doctor to switch to drug on plan's formulary
- If medically necessary, request an exception
- Don't wait until supply runs out to take action



Request a Part D Coverage Determination

§ A coverage determination is the initial decision made by a plan

- Which benefits you're entitled to get
- How much you have to pay for a benefit

§ You, your prescriber, or your appointed representative can request it

§ Time frames for coverage determination request

- May be standard (decision within 72 hours)
- May be expedited (decision within 24 hours)
 - If life or health may be seriously jeopardized



Request an Exception

§ Two types of exceptions

- Tier exceptions
- Formulary exceptions

§ Need supporting statement from prescriber

§ You, your appointed representative, or prescriber can make requests



Formulary Exceptions — Part D

§ Access to Medicare-covered drugs

- Not included on the plan's formulary, or
- Plan has special coverage rules
 - ◻ Prior authorization
 - ◻ Quantity limits
 - ◻ Step therapy

§ Plan can determine the level of cost sharing

Rules Plans Use to Manage Access to Drugs

Prior Authorization	<p>§ Doctor must contact plan for prior approval and show medical necessity before the drug will be covered</p>
Step Therapy	<p>§ Type of prior authorization</p> <p>§ Must first try similar, less expensive drug</p> <p>§ Doctor may request an exception if</p> <ul style="list-style-type: none">• Similar, less expensive drug didn't work, or• Originally prescribed step therapy drug is medically necessary
Quantity Limits	<p>§ Plan may limit drug quantities over a period of time for safety and/or cost</p> <p>§ Doctor may request an exception if additional amount is medically necessary</p>



Formulary Exceptions - Continued

- § Plan must grant a formulary exception if
 - All formulary alternatives aren't as effective and/or
 - Would have adverse effects
- § Plan must grant an exception to a coverage rule
 - Coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or
 - Has caused, or is likely to cause, harm to enrollee



Part D – Approved Exceptions

§ Exception valid for remainder of the year if

- Member is still enrolled
- Prescriber continues to prescribe drug
- Drug stays safe to treat person's condition

§ Plan may extend coverage into new plan year

§ Plan must notify enrollee in writing

- If coverage not extended
- The date coverage will end
- The right to request a new exception

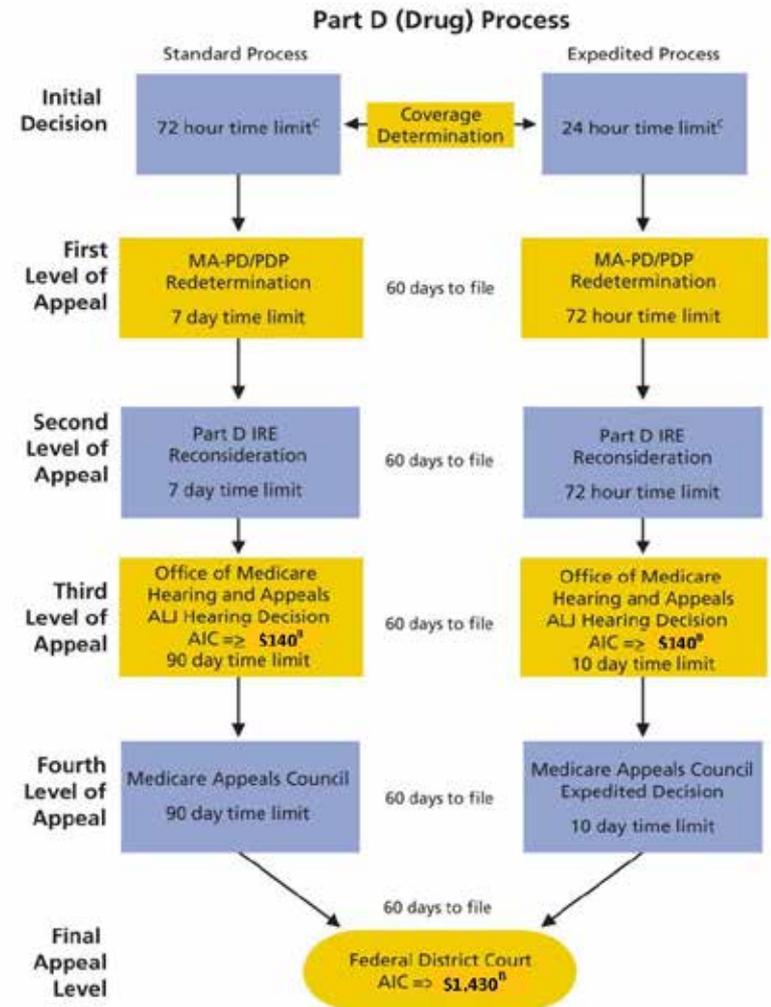


Requesting Part D Appeals

- § If your coverage determination or exception is denied, you can appeal the plan's decision
- § In general, you must make your appeal requests in writing
 - Plans must accept verbal expedited requests
- § An appeal can be requested by
 - You
 - Your doctor or other prescriber
 - Your appointed representative
- § There are five levels of appeals

Medicare Part D Levels of Appeal

- Initial Decision
- Redetermination from the Part D plan (sponsor)
- Reconsideration by a Independent Review Entity (IRE)
- Hearing before an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Review by a federal district court





Required Part D Notices

§ At the pharmacy counter

- Whenever a prescription isn't filled as written
- This isn't a coverage decision

§ After every coverage determination

§ After every appeal decision

§ Adverse decisions must

- Include information on the next appeal level
- Include specific filing instructions
- Provide specific reason(s) for denial



Provider/Plan Disclosure of Personal Health Information (PHI)

§ Plan may disclose relevant PHI to people you identify

- Family member or other relatives
- Close personal friend
- Others (see examples on next slide)

§ May disclose relevant PHI only if

- You're present and agree or plan infers you don't object
- You're not present or are incapacitated, the plan can exercise professional judgment



When Plans May Disclose Personal Health Information

- § To a person's adult child
 - To resolve a claim or payment issue for a hospitalized parent
- § To a human resources representative
 - If the person is on the call or gives permission by phone
- § To a congressional office
 - That faxed your request for congressional assistance
- § To the Centers for Medicare & Medicaid Services (CMS) staff
 - If information satisfies the plan you requested CMS's assistance



Check Your Knowledge – Question 5

A drug plan must respond to a standard coverage determination request for medication within

a. 48 hours

b. 72 hours

c. 60 hours



Lesson 2 — Your Rights in Certain Settings

§ A brief explanation of your rights

- In the hospital
- In a skilled nursing facility
- When getting home health care
- When getting hospice care
- In a Comprehensive Outpatient Rehabilitation Facility



Right to Hospital Care

§ Right to medically-necessary Medicare-covered hospital care

- To diagnose an illness
- To treat an illness or injury
- To get follow-up care

§ You'll receive a notice when admitted

- To an inpatient hospital setting
- An "Important Message From Medicare About Your Rights"



“Important Message From Medicare”

§ Notice signed by you and copy provided

- Explains your rights to
 - q Get all medically-necessary hospital services
 - q Be involved in any decision(s)
 - q Get services you need after you leave the hospital
 - q Appeal discharge decision and steps for appealing decision
 - q Circumstances in which your hospital services may be paid for during the appeal



Plan Fast Appeals Process

§ “Notice of Medicare Non-coverage”

- Provider must deliver at least 2 days before care will end
 - Skilled nursing facility, Comprehensive Outpatient Rehabilitation Facility, hospice or home health care will end

§ Contact Quality Improvement Organization (QIO) if services are ending too soon

- See your notice for how to contact your QIO

§ QIO must notify you of its decision

- Close of business the day after receiving information



Check Your Knowledge – Question 6

The “Important Message From Medicare” is an optional notice provided to a person with Medicare who is admitted to the hospital at the hospital’s discretion.

a. True

b. False



Lesson 3 — Medicare Privacy Practices

§ A brief explanation of Medicare privacy

- Practices
- Notices
- Required and Permitted Disclosures
- Rights

“Notice of Privacy Practices”

§ Tells you how Medicare

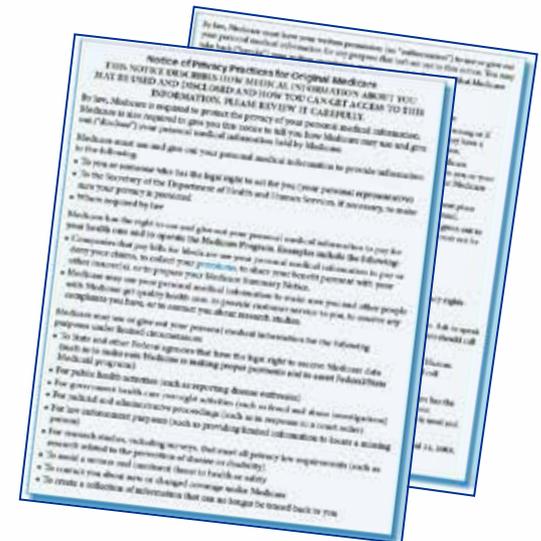
- Must protect the privacy of your personal health information
- Uses and discloses your personal medical information

§ Describes your rights and how you can exercise them

§ Published annually in the “Medicare & You” handbook

§ For more information

- Visit medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227)
- TTY users should call 1-877-486-2048





Required Disclosures

§ Medicare **must** disclose your medical information

- To you
- To someone with the legal right to act for you
- To the Secretary of Health & Human Services
- When required by law



Permitted Disclosures

§ Medicare **may** disclose medical information

- To pay for your health care
- To operate the program
- Examples
 - q To Medicare contractors to process your claims
 - q To ensure you get quality health care
 - q To provide you with customer service
 - q To resolve your complaints
 - q To contact you about research studies



Permitted Disclosures - Continued

§ Medicare **may** disclose your medical information

- To state and federal agencies
- For public health activities
- For government oversight
- For judicial proceedings
- For law enforcement purposes
- To avoid a serious threat to health and safety
- To contact you regarding a Medicare benefit
- To create a non-traceable collection of information



Personal Medical Information Authorization

- § Written permission (authorization) is required
 - For Medicare to use or give out your personal medical information
 - For any purpose not set out in the “Privacy Notice”
- § You may revoke your permission at any time



Personal Medical Information Privacy Rights

- § See and copy your personal medical information
- § Correct medical information you believe is wrong or incomplete
- § Know who your medical information was sent to
- § Communicate in a different manner
- § Ask Medicare to limit use of your medical information
 - To pay your claims and run the program
- § Get a written privacy notice



If Privacy Rights Are Violated

§ You may file a complaint

- Call 1-800-MEDICARE (1-800-633-4227)
TTY users should call 1-877-486-2048 or
- Contact the U.S. Department of Health and Human Services Office for Civil Rights
 - q Visit [hhs.gov/ocr/office/index.html](https://www.hhs.gov/ocr/office/index.html) or
 - q Call 1-866-627-7748. TTY users should call 1-800-537-7697.
- Won't affect your Medicare benefits

Check Your Knowledge – Question 7

Medicare may disclose your personal medical information at will, in whole or part, for any purpose.

a. True

b. False



Lesson 4 — Medicare Rights and Protections Resources

- § Advance Directives
- § Medicare Ombudsman
- § Other sources for information about Medicare rights and protections



Advance Directives

- § Protect yourself
- § Let people know your wishes now
 - Should a time come when you can't speak for yourself
- § Complete a "health care advance directive"
 - Identifies who you want to speak for you
 - What kind of health care you want
 - What kind of health care you don't want



Medicare Beneficiary Ombudsman

§ Reports to Congress

§ Works to ensure people with Medicare

- Get information and help they need
- Understand their Medicare options
- Apply their rights and protections

§ May identify and track issues

- Payment policies
- Coverage policies



How the Ombudsman Helps

- § Ensures prompt organization response
 - The Ombudsman can help if you
 - q Need help filing an appeal
 - q Have a problem joining/leaving a Medicare Advantage Plan
 - q Have questions about Medicare premiums
 - q Need help understanding your rights/protections



Check Your Knowledge – Question 8

A living will is a legal document used to name the person you wish to make health care decisions for you if you aren't able to make them yourself.

a. True

b. False

Medicare Rights and Protections Resource Guide

Resources	Medicare Products	
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) medicare.gov</p> <p>medicare.gov/get-help/ombudsman</p> <p>medicare.gov/claims-and-appeals</p> <p>cms.gov/bni (Beneficiary Notice Initiative)</p> <p>Department of Health and Human Services Office for Civil Rights hhs.gov/ocr/office/index.html 1-866-627-7748 1-800-537-7697 for TTY users</p>	<p>State Quality Improvement Organization*</p> <p>Independent Review Entity (Medicare Advantage & Part D claims only) *</p> <p>State Health Insurance Assistance Programs *</p> <p>U.S. Railroad Retirement Board rrb.gov</p> <p>hhs.gov</p> <p>Medicare Managed Care Manual, Chapter 13, Beneficiary Grievances, Organization Determinations, and Appeals: cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c13.pdf</p> <p>*For telephone numbers, call CMS 1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users</p>	<p>“Medicare & You Handbook” CMS Product No. 10050</p> <p>“Medicare Rights & Protections” CMS Product No. 11534</p> <p>To access these products: View and order single copies at medicare.gov.</p> <p>Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.</p>

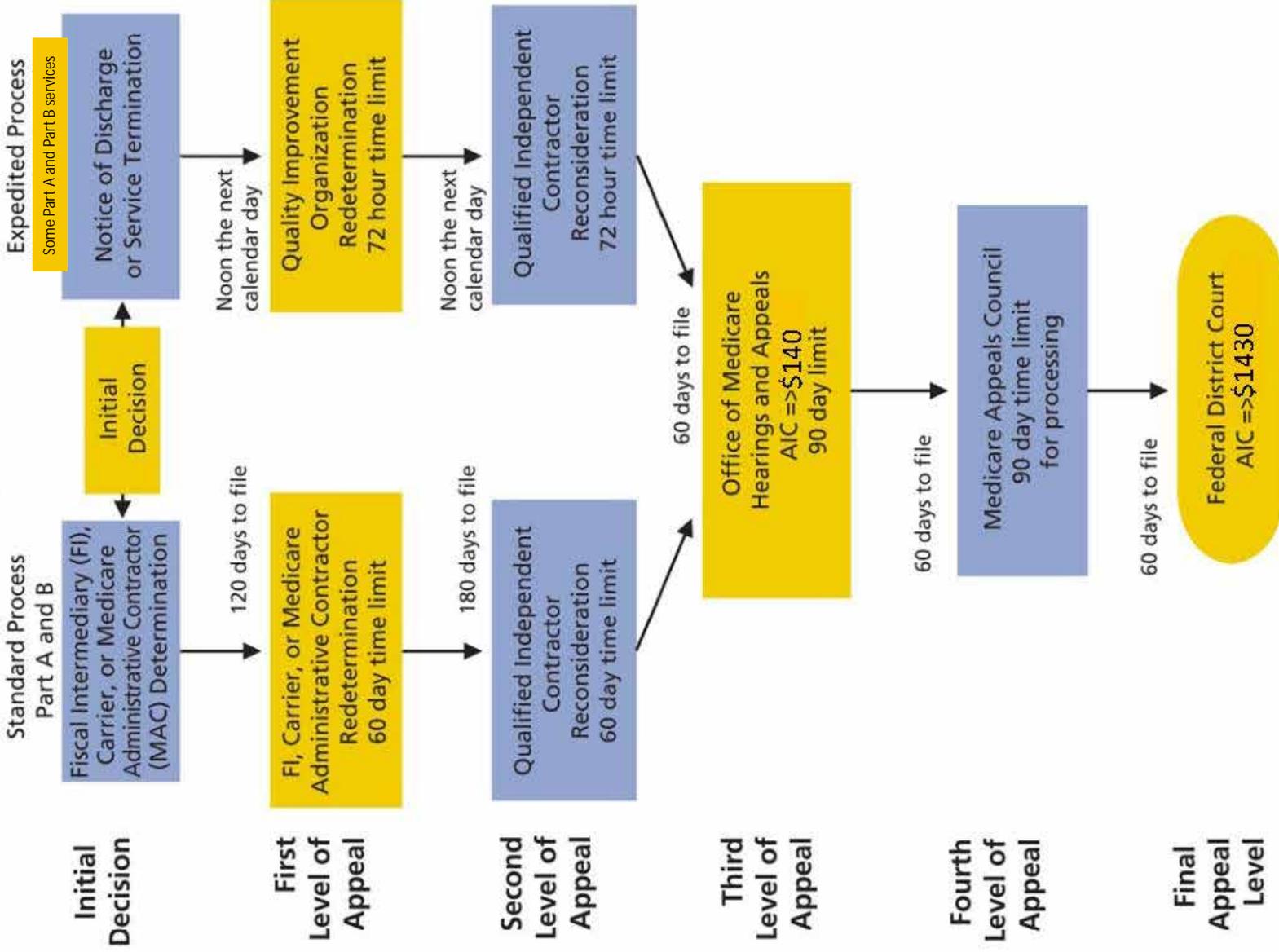


This training module is provided by the CMS National Training Program (NTP). For questions about training products email training@cms.hhs.gov.

To view all available NTP materials, or to subscribe to our email list, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram.

Appendix A

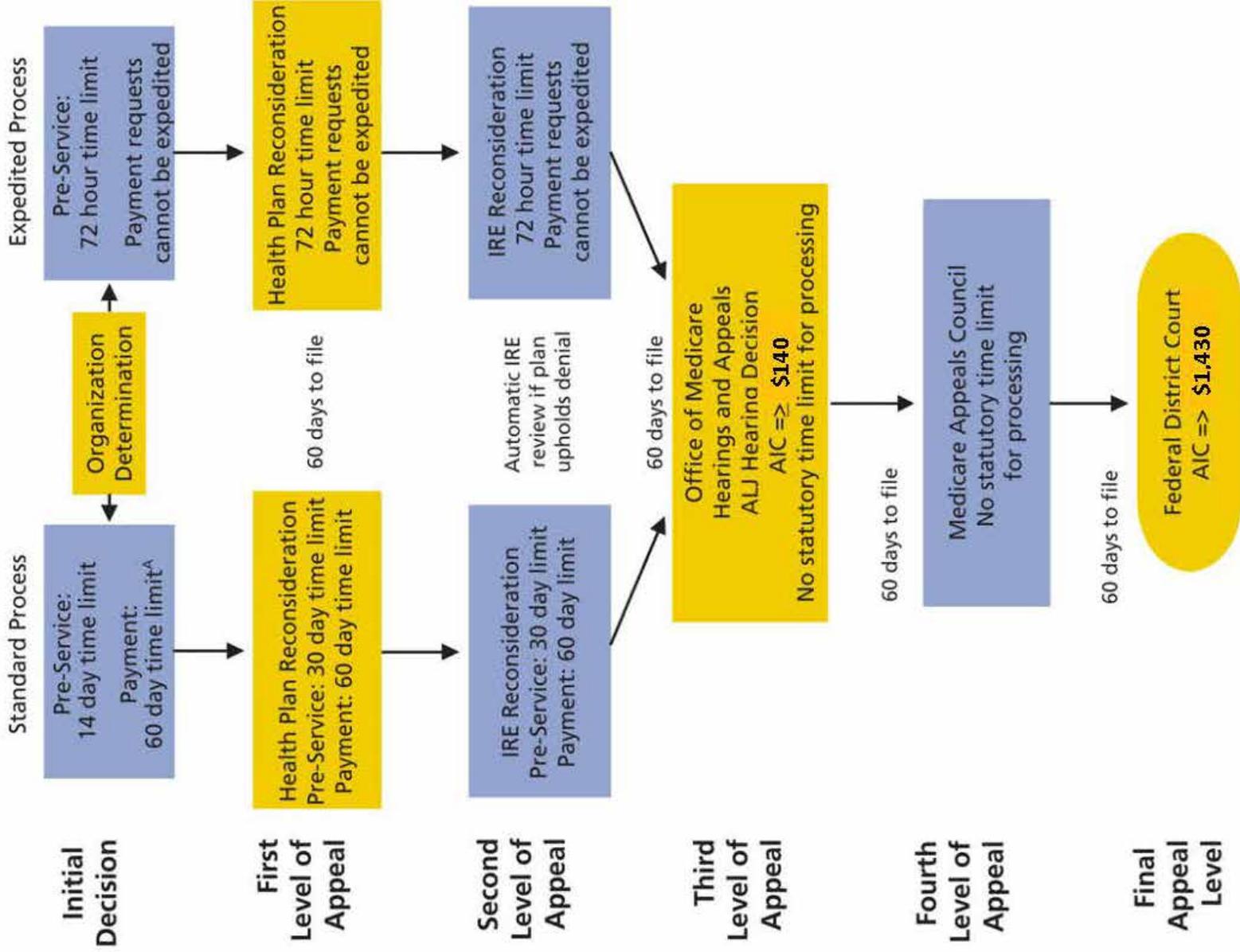
Parts A & B (Fee-for-Service) Process



AIC = Amount in Controversy/MA-PD = Medicare Advantage/Prescription Drug A: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge
 MMA = Medicare Prescription Drug B: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2014 AIC amounts.
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Appendix B

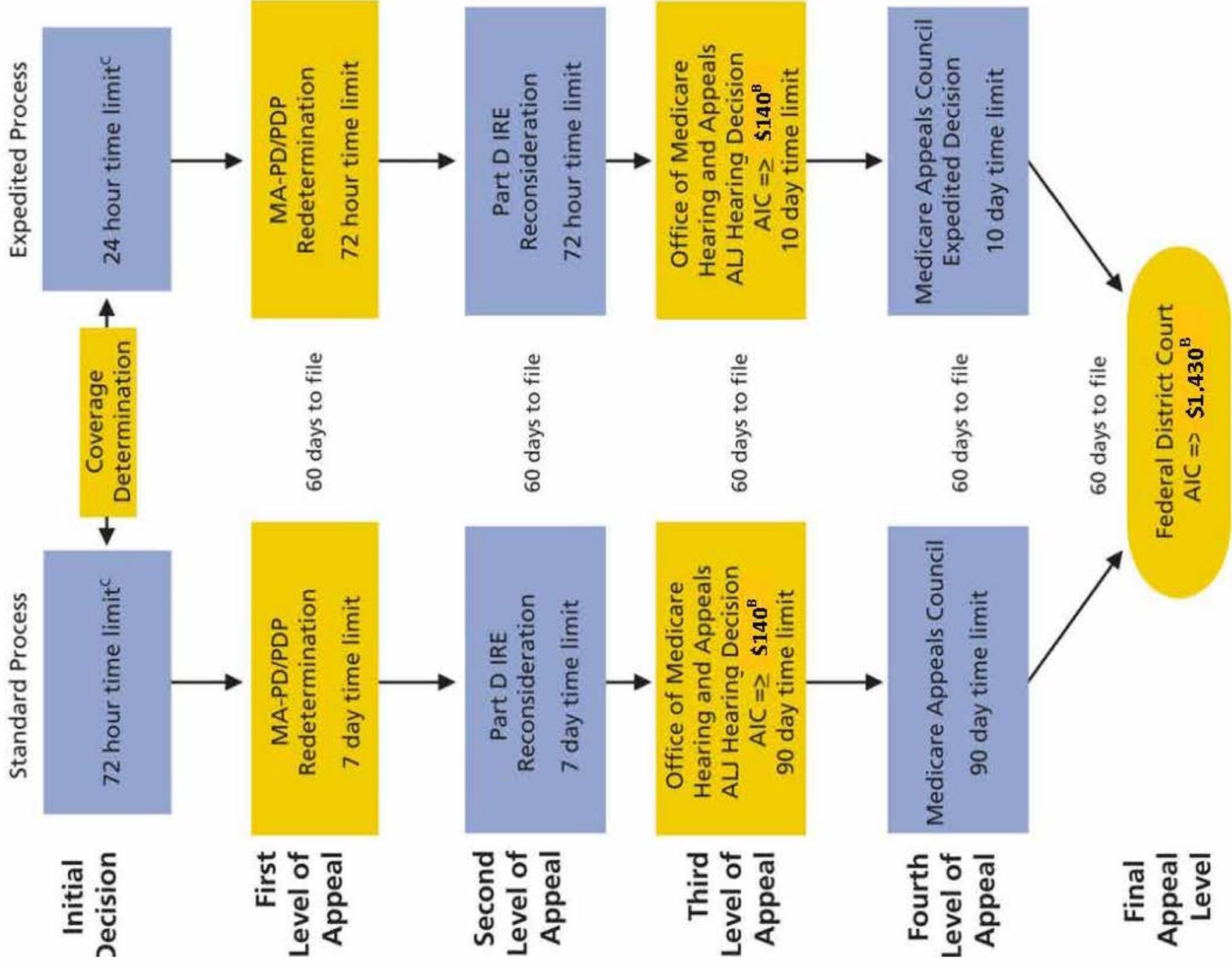
Part C (MA) Process



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Appendix C

Part D (Drug) Process



AIC = Amount in Controversy/MA-PD = Medicare Advantage/Prescription Drug A: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days. ALJ = Administrative Law Judge
 MMA = Medicare Prescription Drug B: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2014 AIC amounts. Contractor
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Appendix D

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1830.