Disclosure to CMS Web Page

These screen shots from the Disclosure to CMS Form include references from the Disclosure to CMS guidance. The Disclosure to CMS form must be completed on-line at https://www.cms.hhs.gov/apps/ccdisclosure/ .
The disclosure to CMS web form below is not valid for submission to CMS.

BOX A

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

Creditable Coverage Disclosure to CMS Website

Please refer to the Disclosure to CMS Guidance at http://www.cms.hhs.gov/CreditableCoverage/ for detailed information when completing this form.

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

1. Name of Entity Offering Coverage
2. Entity Federal ID Number ex: xx-xxxxxxx
3. Street Address of Entity
   City State Zip Code
4. Phone Number of Entity ex: xxx-xxx-xxxx
5. Type of Coverage (Choose One):

GROUP HEALTH PLAN:
- Employer Sponsored Plan
- Union/Taft Hartley Sponsored Plan
- Church
- Federal Government
- State Government
- Local Government
- Other Entity

STATE-SPONSORED PLANS:
- Medicaid
- State Pharmacy Assistance Program (SPAP)
- State High Risk Pool
- Other State-Sponsored Plan:

MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205):
- Standardized Plan (H, I, J)
- Pre-standardized Plan
- Waiver State Plan
- Innovative Benefit Rider

- INDIVIDUAL HEALTH INSURANCE (Non-Medigap Plans)
- VETERANS COVERAGE (under Chapter 17 of Title 38 U.S.C.)
- MILITARY COVERAGE (under Chapter 55 of Title 10, U.S.C., including TRICARE)
- INDIAN HEALTH SERVICE
- TRIBE OR TRIBAL ORGANIZATION
- URBAN INDIAN ORGANIZATION
- OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS

  Please Fill in Type of Plan:

6. **How many Prescription Drug Options offered under this Coverage?**

Disclosure to CMS Web Page

BOX B

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

7. 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.**

Box C - All Options Offered Are Creditable

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

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.**

You have select All Options Offered Are Creditable.

Period covered by this Disclosure:

8. ▪ Plan Year Beginning Date (MM/DD/YYYY) _____ Plan Year Ending Date (MM/DD/YYYY) _____

9. ▪ Total Number of Medicare Part D Eligible Individuals expected to be covered under these Option(s) as of the Plan Year Beginning Date stated above: _____

10. ▪ Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan _____

11. ▪ Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the entity (MM/DD/YYYY) _____

12. ▪ Is this a change to a previous disclosure of creditable coverage status provided to CMS? Yes ○ No ○
  - ▪ If yes, include the effective date(s) of this change (MM/DD/YYYY) _____
  - ▪ If yes, date Entity completed the disclosure to Medicare Part D Eligible Individuals of this change in Creditable Coverage(MM/DD/YYYY) _____

Disclosure to CMS Web Page

Box D - All Options Offered Are Non-Creditable

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

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.**

You have select All Options Offered Are Non-Creditable.

Period covered by this Disclosure:

8. ▪ Plan Year Beginning Date (MM/DD/YYYY) _____ Plan Year Ending Date (MM/DD/YYYY) _____

9. ▪ Total Number of Medicare Part D Eligible Individuals expected to be covered under these Option(s) as of the Plan Year Beginning Date stated above: _____

10. ▪ Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan _____

11. ▪ Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the entity (MM/DD/YYYY) _____

12. ▪ Is this a change to a previous disclosure of creditable coverage status provided to CMS? Yes ○ No ○
    - ▪ If yes, include the effective date(s) of this change (MM/DD/YYYY) _____
    - ▪ If yes, date Entity completed the disclosure to Medicare Part D Eligible Individuals of this change in Creditable Coverage(MM/DD/YYYY) _____

Box E-There are some Creditable or Non-Creditable Options Offered

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

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.**

You have Selected there are some Creditable or Non-Creditable Options Offered.

Period covered by this Disclosure:

8. ▪ Plan Year Beginning Date (MM/DD/YYYY) [ ] Plan Year Ending Date (MM/DD/YYYY) [ ]

A. ▪ How many options offered under this Plan are creditable? [ ]

9. ▪ Total Number of Medicare Part D Eligible Individuals expected to be covered under these creditable Benefit Option(s) as of the Plan Year Beginning Date stated above: [ ]

10. ▪ Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan [ ]

B. ▪ How many Options offered are not creditable? [ ]

9. ▪ Total Number of Medicare Part D Eligible Individuals expected to be covered under non-creditable Option(s) as Plan Year Beginning Date stated above: [ ]

10. ▪ Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan [ ]

11. ▪ Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the Entity (MM/DD/YYYY) [ ]

12. ▪ Is this a change to a previous disclosure of creditable coverage status provided to CMS? Yes ○ No ○
  - ▪ If yes, include the effective date(s) of the change (MM/DD/YYYY) [ ]
  - ▪ If yes, date Entity disclosed to Medicare Part D Eligible Individuals this change in Creditable Coverage(MM/DD/YYYY) [ ]

Disclosure to CMS Web Page

BOX E

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS

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.

13. (Name of Entity's Authorized Individual) (Title)

(Email of Entity's Authorized Individual) Date (MM/DD/YYYY)

Submit the form | Clear All Fields

Disclosure to CMS Web Page

BOX F

SAMPLE DISCLOSURE FORM – NOT FOR SUBMISSION TO CMS