Disclosure to CMS Form

Updated June 01, 2007

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Disclosure to CMS Form

Form Approved
OMB No. 0938-1013

Entities that are required to provide a disclosure of creditable coverage status to CMS must complete the following online Disclosure to CMS Form. Refer to the links on the left side of this webpage to the Disclosure to CMS Guidance and Commonly Asked Questions and Helpful Hints documents to assist you when completing this form.

The disclosure submission process is composed of the following steps to complete the online Disclosure to CMS Form:

- **Step 1 - Enter the Disclosure Information**
- **Step 2 - Verify and Submit Disclosure Information, and**
- **Step 3 - Receive Submission Confirmation**

Note: Once you have completed Step 3, you should print a copy of the confirmation page for your records.

Please complete the following information for each **Type of Coverage** offered by the Entity/Plan Sponsor.

Entity/Plan Sponsor Information:

Entity Name

Entity Federal ID Number (##-#######)

Entity Street Address

City

State (US Only)

Zip Code

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Country

Phone Number (###-###-####)

Coverage Type:

(View of Drop Down Items)
GROUP HEALTH PLAN: Employer Sponsored Plan
GROUP HEALTH PLAN: Union/Taft Hartley Sponsored Plan
GROUP HEALTH PLAN: Church
GROUP HEALTH PLAN: Federal Government
GROUP HEALTH PLAN: State Government
GROUP HEALTH PLAN: Local Government
GROUP HEALTH PLAN: Other Entity
STATE-SPONSORED PLANS: Medicaid
STATE-SPONSORED PLANS: State Pharmacy Assistance Program (SPAP)
STATE-SPONSORED PLANS: State High Risk Pool
STATE-SPONSORED PLANS: Other State-Sponsored
MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205): Standardized Plan (H, I, J)
MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205): Pre-Standardized Plan
MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205): Waiver State Plan
MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205): 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

If you selected "STATE-SPONSORED PLAN: Other State-Sponsored" or "OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS," please specify Other Type of Coverage below.

Other Type of Coverage

How many Prescription Drug Options offered under this Coverage?

Please select **ONE** of the following to continue and complete the required disclosure information.

- **All Options Offered Are Creditable**
- **All Options Offered Are Non-Creditable**
- **There are Some Creditable and Non-Creditable Options Offered**

Continue | Clear All Fields

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You have selected **All Options Offered Are Creditable**. Please complete the following information pertaining to this Option.

All Options Offered Are Creditable

Plan Year Beginning Date (MM/DD/YYYY)

Plan Year Ending Date (MM/DD/YYYY)

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

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

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

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, enter the date this Entity disclosed to Medicare Part D Eligible Individuals about this change in Creditable Coverage(MM/DD/YYYY)

I understand and agree to the following statements:

1. That this submission supersedes any previous submission of this information with dates prior to the date below;
2. 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;
3. That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
4. That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

Entity's Authorized Individual Name

Entity's Authorized Individual Title

Entity's Authorized Individual Email

(If no email address is available, Please enter **noname@noisp.com**)

Date (MM/DD/YYYY)

Continue | Clear All Fields | Go Back to Edit Information

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You have selected **All Options Offered Are Non-Creditable**. Please complete the following information pertaining to this Option.

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All Options Offered Are Non-Creditable

Plan Year Beginning Date (MM/DD/YYYY)

Plan Year Ending Date (MM/DD/YYYY)

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

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

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

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, enter the date this Entity disclosed to Medicare Part D Eligible Individuals about this change in Creditable Coverage (MM/DD/YYYY)

I understand and agree to the following statements:

1. That this submission supersedes any previous submission of this information with dates prior to the date below;
2. 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;
3. That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
4. That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

Entity's Authorized Individual Name

Entity's Authorized Individual Title

Entity's Authorized Individual Email

(If no email address is available, Please enter **noname@noisp.com**)

Date (MM/DD/YYYY)

Continue | Clear All Fields | Go Back to Edit Information

Form CMS-10198 (04/07)

You have selected **There are Some Creditable and Non-Creditable Options Offered**. Please complete the following information pertaining to these Options.

There are Some Creditable and Non-Creditable Options Offered

Plan Year Beginning Date (MM/DD/YYYY)

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Plan Year Ending Date (MM/DD/YYYY)

How many Options offered under this Plan are creditable?

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

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

How many Options offered under this Plan are not creditable?

Total Number of Medicare Part D Eligible Individuals expected to be covered under non-creditable Option(s) as of the Plan Year Beginning Date stated above

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

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

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, enter the date this Entity disclosed to Medicare Part D Eligible Individuals this change in Creditable Coverage (MM/DD/YYYY)

I understand and agree to the following statements:

1. That this submission supersedes any previous submission of this information with dates prior to the date below;
2. 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;
3. That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
4. That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

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Entity's Authorized Individual Name

Entity's Authorized Individual Title

Entity's Authorized Individual Email

(If no email address is available, Please enter **noname@noisp.com**)

Date (MM/DD/YYYY)

Continue | Clear All Fields | Go Back to Edit Information

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SAMPLE DISCLOSURE TO CMS FORM – NOT FOR SUBMISSION TO CMS

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Please review and confirm your disclosure data entry. Select the <Submit Disclosure> button below to submit your Disclosure to CMS Form to CMS. Select the <Back to Edit Information> button below to change the information.

Step 2 - Verify and Submit Disclosure Information

Entered Disclosure Information:

Entity Offering Coverage Name: ABC UNION - TEST ENTRY

Entity Federal ID Number: 12-3456789

Entity Street Address: 123 ANY STREET

City: ANY TOWN

State: Delaware

Zip Code: 19975

Country: United States

Entity Phone Number: 987-654-3210

Type of Coverage : GROUP HEALTH PLAN: Union/Taft Hartley Sponsored Plan

How many Prescription Drug Options offered under this Coverage? 2

Options Offered: There are Some Creditable and Non-Creditable Options Offered.

Plan Year Beginning Date: 04/01/2007

Plan Year Ending Date: 03/31/2008

How many Options offered under this Plan are creditable? 1

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: 3

How many Options offered are not creditable? 1

Total Number of Medicare Part D Eligible Individuals expected to be covered under non-creditable Option(s) as of the Plan Year Beginning Date stated above: 3

Estimated number of those Medicare Part D Eligible Individuals stated above expected to be covered through an Employer/Union Retiree Group Health Plan: 3

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Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the Entity: 11/05/2006

Is this a change to a previous disclosure of Creditable Coverage Status provided to CMS? No

Entity's Authorized Individual Name: JOHN Q PUBLIC

Entity's Authorized Individual Title: UNION FUND MANAGER

Entity's Authorized Individual Email: JOHN.Q.PUBLIC@NOISP.COM

Date(MM/DD/YYYY): 04/02/2007

Submit Disclosure   Go Back to Edit Information

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Thank you! Your Disclosure to CMS Form has been submitted successfully to CMS. Please print a copy of this confirmation page for your records.

Step 3 - Receive Submission Confirmation

Submitted Information:

Entity Offering Coverage Name: ABC UNION - TEST ENTRY

Entity Federal ID Number: 12-3456789

Entity Street Address: 123 ANY STREET

City: ANY TOWN

State: Delaware

Zip Code: 19975

Country: United States

Entity Phone Number: 987-654-3210

Type of Coverage : GROUP HEALTH PLAN: Union/Taft Hartley Sponsored Plan

How many Prescription Drug Options offered under this Coverage? 2

Options Offered: There are Some Creditable and Non-Creditable Options Offered.

Plan Year Beginning Date: 04/01/2007

Plan Year Ending Date: 03/31/2008

How many Options offered under this Plan are creditable? 1

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: 3

How many Options offered are not creditable? 1

Total Number of Medicare Part D Eligible Individuals expected to be covered under non-creditable Option(s) as of the Plan Year Beginning Date stated above: 3

Estimated number of those Medicare Part D Eligible Individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan: 3

Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the Entity: 11/05/2006

Is this a change to a previous disclosure of Creditable Coverage Status provided to

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CMS? No

Entity's Authorized Individual Name: JOHN Q PUBLIC

Entity's Authorized Individual Title: UNION FUND MANAGER

Entity's Authorized Individual Email: JOHN.Q.PUBLIC@NOISP.COM

Date(MM/DD/YYYY): 04/02/2007

Input Another Record

Form CMS-10198 (04/07)