CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

DEPARTMENT OF H
CENTERS FOR MEI

Third Party Administrators' Submission Requirements fo

Third Party Administrator & Pharmacy Benefit Manager Information

Name of Third Party Administrator (TPA) or Pharmacy Benefit Manager (PBM):

TPA or PBM Contact Information

Contact Name:
Title or Organizational Role of Contact Person:
Telephone Number:
Email Address:

Alternate Contact Name:
Title or Organizational Role of Alternate Contact:
Telephone Number:
Email Address:

Payment Information

Dollar Amount of Payments for C
Beneficiaries Paid by a TPA

calculation from Self Insured Plan Info Tab

Number of Participants and Bene

calculation from Self Insured Plan Info Tab

Attestation

On behalf of my organization, I attest that the pay
54.9815-2713A(b)(2) or 29 CFR § 2590.715-2713A
certify that the information contained in this subm
and I attest that I have taken reasonable steps to a
that my organization will promptly inform CMS if r
submission is untrue, incorrect, or incomplete.

Signature of Attestor:
Title or Organizational Role of Attestor:
Date signed:
Email Address:
Telephone Number:

Please Email this form to FF

HEALTH AND HUMAN SERVICES
DICARE & MEDICAID SERVICES

or Claims Cost Reimbursement of Certain Preventative Services

	extension:

	extension:

ontraceptive Services For Plan Participants &	$0.00
eficiaries in Each Self-insured Group Health Plan	0

ments for contraceptive services were made in compliance with 26CFR § (b)(2). I certify that I am authorized to attest on behalf of my organization. I ission is true, correct, and complete to the best of my knowledge and belief, ascertain the truth, correctness and completeness of this information. I attest my organization becomes aware that any of the information contained in this

	ex: mm/dd/yyyy
extension:	

Muserfeeadjustments@cms.hhs.gov

DEPARTMENT OF
CENTERS FOR ME

Data Elements for Third Party Administrators' Submission Requi

Information

Self Insured Plan HIOS ID	Date TPA or PBM Notification of Intent Sent to HHS *(please use this date format - mm/dd/yyyy)*

Please Email this form to FI

HEALTH AND HUMAN SERVICES

DICARE & MEDICAID SERVICES

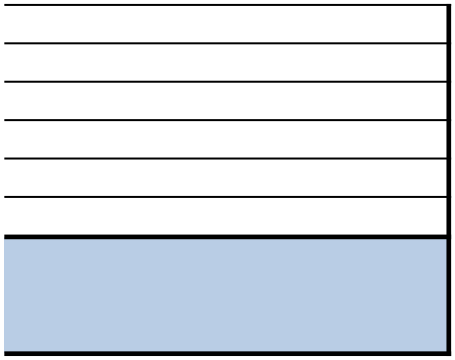
rements for Claims Cost Reimbursement of Certain Prever

Number of Participants and Beneficiaries in Self Insured Plan Administered by the TPA or PBM	Amount of Total Contraceptive Cla

FMuserfeeadjustments@cms.hhs.gov

ntative Services

ims Paid by the TPA or PBM



DEPARTMI
CENTERS I

Third Party Administrators' Submission Requirements
For

Form Objective	This form allows third party admir for contraceptive services made u organizations receive an accommo or make payment for these service As is described in 26 CFR 54.9815- issuers that have entered into an a participants and beneficiaries in se This form is designed for TPAs and the version of this form specific to

Submission Guidelines	Email this form to FFMuserfeeadju 45 CFR 156.50(d)(2)(iii) requires a contraceptive services to CMS in t 45 CFR 156.50(d)(2)(iii)(A) through • Identifying information for each • Identifying information for each • The total number of beneficiarie • The total dollar amount of paym • An attestation that the payment

This section lists each data element required for the form and

Column Name	*Column and Cell #*
	Inf
	Third Party Administrator (TPA) and
Name of TPA or PBM	C11
	Third Party Adminis
TPA User Fee Adjustment Contact Name	D17
Title or Organizational Role of Contact Person	D18
Telephone Number/Extension	D19 and E19
Email Address	D20
Alternate TPA User Fee Adjustment Contact Name	D23

Title or Organizational Role of Contact Person	D24
Telephone Number/Extension	D25 and E25
Email Address	D26
	Payr
Dollar Amount of Payments for Contraceptive Services for Plan Participants & Beneficiaries Paid By a TPA	F30
Number of Participants and Beneficiaries in Each Self Insured Plan	F34
Attestation Text	C39

Signature of Attester	D41
Title or Organizational Role of Attester	D42
Date Signed	D43
Email Address	D44
Telephone Number/Extension	D45 and E45
	Self Insured
Self Insured Plan HIOS ID	B10 – B47
Date of TPA or PBM Notification of Intent Sent to HHS *(please use this date format - mm/dd/yyyy)*	C10 – C47
Number of Participants and Beneficiaries In Self Insured Plan Administered by the TPA or PBM	D10 – D47

Amount of Total Contraceptive Claims Paid by the TPA or PBM	E10 – E47

ENT OF HEALTH AND HUMAN SERVICES (HHS)
FOR MEDICARE & MEDICAID SERVICES (CMS)

for Claims Cost Reimbursement of Certain Preventative Services
m Instructions

nistrators (TPAs) and pharmacy benefit managers (PBMs) to submit information on payments nder contract with an eligible organization as described in 26 CFR 54.9815-2713A. Eligible odation relating to contraceptive coverage so that they are not required to provide, arrange, es.

2713A(b)(3), CMS will use the amounts reported in this form to adjust FFM user fees for FFM agreement with a TPA or PBM that is arranging for contraceptive services to be provided to elf-insured plans of organizations that receive the accommodation.

l PBMs only. Issuers submitting information on payments for contraceptive services should use issuers.

ıstments@cms.hhs.gov

participating TPA seeking an FFM user fee adjustment to submit payment amounts for
he year following the calendar year in which the contraceptive services were provided.

ı (E) specifies that TPAs must submit:
TPA,
self-insured group plan for which the TPA is seeking an adjustment,
:s and participants in each self-insured group plan,
ıents for contraceptive services, and
s for contraceptive services were made in compliance with federal law.

detailed instructions on how to populate each data field in the workbook.

Instructions
ormation Tab
d Pharmacy Benefit Manager (PBM) Information
Enter the business name of the TPA or PBM submitting the form.
trator (TPA) Contact Information
Enter the name of the person CMS can contact if CMS identifies a discrepancy or has a question about the TPA's submission.
Enter the title or organizational role of the TPA user fee adjustment contact identified above.
Enter the telephone number of the TPA contact person and include an extension, if applicable.
Enter the email address of the TPA contact person.
Enter the name of an additional contact available to answer questions about the TPA's submission.

Enter the title or organizational role of the alternate TPA user fee adjustment contact identified in DE23

Enter the telephone number of the alternate TPA contact person and include an extension, if applicable.

Enter the email address of the alternate TPA contact person.

nent Information

Do not populate this field; this field auto populates with the sum of all amounts in Column E in the Self Insured Plan Information sheet.

This amount reflects the total dollar amount of payments made by a TPA during the applicable calendar year.

Do not populate this field, this field auto populates with the sum of all amounts in Column D of in the Self Insured Plan Information Sheet.

This number represents the total number of covered lives of participants and beneficiaries in self-insured plans for which the TPA or PBM arranged for the provision of contraceptive services during the applicable calendar year.

Attestation

This attestation certifies that:
• The reported payments for contraceptive services were made in compliance with federal law [26 CFR § 54.9815-2713A(b)(2) or 29 CFR § 2590.715-2713A(b)(2)],
• The attester is authorized to attest on behalf of the organization,
• The attester certifies that the information contained in the submission is true, correct, and complete to the best of the attester's knowledge or belief,
• The attester has taken reasonable steps to ascertain the truth, correctness, and completeness of the reported information, and
• The organization will promptly inform CMS if the organization becomes aware that any information submitted on the form is untrue, incorrect, or incomplete.
Read the text of the attestation carefully before signing.

Signature of the person responsible for attesting to the stipulations presented in the attestation statement.
Enter the title of the attester.
Enter the date the attestation was signed in eight-digit, mm/dd/yyyy format.
Enter the email address of the attester.
Enter the telephone number of the attester and include an extension, if applicable.

d Plan Information Tab

Enter the five-digit Health Insurance Oversight System (HIOS) ID for each self insured plan for which the TPA intends to seek an adjustment.
Enter the date the TPA/PBM sent a notification to CMS indicating its intent to enter into an arrangement with a participating FFM issuer seeking an adjustment to the FFM user fee. Enter the date the TPA/PBM notified HHS of their intent to seek a user fee adjustment in eight-digit, mm/dd/yyyy format. HHS has issued clarifying guidance indicating that TPAs/ PBMs must notify HHS of their intent for an issuer to seek a user fee adjustment on their behalf by [Insert 30 days after finalization of the PRA]. The notification of intent letter is available on the CCIIO website. TPAs/PBMs should complete the letter and email it to FFMuserfeeadjustments@cms.hhs.gov
Enter the total number of covered lives for participants and beneficiaries in the self insured plan for which the TPA/PBM administered or arranged for the provisions of contraceptive services in the year preceding the current calendar year. This number will reflect the total covered life enrollment in the self insured plan administered by the TPA/PBM as of December 31 of the year preceding the current calendar year. This number will count all participants and beneficiaries in the self insured plan administered by the TPA/PBM, irrespective of whether or not the plan participant or beneficiary utilized contraceptive services.

The total dollar amount for contraceptive claims, as defined at §147.130(a)(1)(iv), incurred by plan participants and beneficiaries as of December 31 in the year preceding the current calendar year. The dollar value of claims incurred by this date are counted in the total, even if the claims were not paid by December 31st.

The total dollar amount equals the payment for contraceptive services that the TPA or PBM payments made directly, or the payment amount that the TPA or PBM arranged for an issuer or other entity to make on its behalf.