2018 Survey
INITIAL COVER LETTER
[THE HEADING ABOVE IS NOT TO BE INCLUDED ON THE LETTER SENT TO BENEFICIARIES]

[VENDOR LETTERHEAD] **[VENDOR RETURN ADDRESS]**
[LAST DATE OF 1ST SURVEY MAILING]

Dear [FIRST LAST]:

As a person with Medicare, you deserve to get the highest quality medical care when you need it, from doctors, nurses and other health care providers you trust. The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program and its responsibility is to ensure that you get high quality care. One of the ways CMS can fulfill that responsibility is to find out directly from you about the care you are currently receiving under the Medicare program.

CMS is conducting a survey of people with Medicare to learn more about the health care services they receive. CMS has contracted with [VENDOR NAME] to conduct this survey. Your name was selected at random by CMS from among the individuals who have visited the provider named in the enclosed survey. We would greatly appreciate it if you would take the time to fill out the survey. It should take you about 13 minutes. The accuracy of the results depends on getting answers from you and other people with Medicare selected for this survey. This is your opportunity to help CMS serve you better.

Please answer the questions in the survey thinking about your experiences in the last six months. [VENDOR NAME] will hold your identifying information and all information you provide in confidence, and your information is protected by U.S. federal law under the Privacy Act of 1974. [VENDOR NAME] will not share your information with anyone other than authorized persons at CMS, except as required by law. [VENDOR NAME] will not share your individual survey with any of your health care providers. **You do not have to participate in this survey. Your help is voluntary, and your decision to participate or not to participate will not affect your Medicare benefits in any way.**

We hope that you will take this opportunity to help CMS learn about the quality of care you receive. If you have any questions about the survey, please call [VENDOR NAME] toll-free at [VENDOR NUMBER], between 9:00 am to 6:00 pm [VENDOR TIME ZONE], Monday through Friday. Thank you in advance for your participation.

Sincerely,

[SIGNED BY SENIOR LEADER AT VENDOR ORGANIZATION]

PRA Disclosure Statement

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 0938-1222. The time required to complete this information collection is estimated to average 12.9 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(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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