DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850

Notice of Corrective Action Re-Assessment

Date of Notice: FULLDATE

CONTACTNAME
JOBTITLE
CENAME
ADDRESS1
ADDRESS2
CITY, ST ZIP

Re: Corrective Action Number **XXXXX**

Dear TITLE LASTNAME:

On (month, day, year), the Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services' (CMS), opened a corrective action based on the violations discovered during the **<Covered Entity Name>** 2017 assessment.

As part of the corrective action process, <**Covered Entity Name**> submitted a corrective action plan (CAP) that addresses the violations previously discovered. Our records indicate that <**Covered Entity Name**> has completed this CAP and is ready for re-assessment for compliance.

Please upload the following documents or transactions specific to the violations cited, for re-assessment purposes:

1. Example: Two production 835 files created after (month, day, year) that contain one or more adjusted claim payments at the claim level.
2. Example: Website URL to the updated 835 Companion Guide for <**Covered Entity Name**>.

Using the previously provided login information, please upload all requested information in this letter to your secure portal site by (month, day, year) so that the re-assessment can be conducted.

We will conduct the re-assessment within 14 business days of receiving the requested information, and will notify <**Covered Entity Name**> of the re-assessment results.

If you have any questions about this letter, please contact (contact name) at contact_name@cms.hhs.gov, or 555-555-5555. When contacting this office, please include the corrective action number located at the top of this letter.

Sincerely,
Madhu Annadata, Director
Division of National Standards
Office of Information Technology

cc:
Contact Name

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information, unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-XXXX (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **[10 hours]** per response (4 forms x 60 minutes/form), 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:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Cecily Austin at cecily.austin@cms.hhs.gov or Kevin Stewart at kevin.stewart@cms.hhs.gov .