

**Program Audit Data Request
Part D Formulary and Benefit Administration (FA)
Supplemental Questionnaire**

Name of Sponsoring Organization:

Enter your response here

Contract Numbers:

Enter your response here

Name and Title of Person Completing Questionnaire:

Enter your response here

Date Completed:

Select date

This questionnaire is designed to assist CMS in understanding the unique qualities of your organization's FA program operations.

Please upload the completed form to HPMS within 5 business days of receiving your audit engagement letter.

We recognize that your time is valuable and appreciate your availability to provide responses to our questions regarding the FA program operations. The responses to these questions may be discussed during the FA audit.

1. For purposes of transition, do you utilize prior claims history for existing enrollees having a Plan Benefit Package (PBP) change?

Select Yes or No

If yes, do not include these enrollees in Table 4: New Enrollee Record Layout. If no, include these enrollees in Table 4: New Enrollee Record Layout.

2. Do you have non-calendar year Employer Group Waiver Plans (EGWPs)? If yes, please identify the contract IDs and respective PBPs with non-calendar year EGWPs.

Enter your response here

3. Which submitted claim fields (and their associated values) do you use to determine if any enrollee is subject to long-term care requirements?

Enter your response here

4. During the review of the sample cases, who will be walking auditors through the various screens within the applicable platforms reviewed during audit?

Select Sponsoring Organization or Delegated Entity

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- 5. If you utilize any methods (other than claims history) to ascertain new versus ongoing therapy for enrollees, please describe. If not, enter NA.**

Enter your response here

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