Part C and D Model Precluded Provider Letter

[Instructions: This model letter could be used by Medicare plans and Part D plans to alert a member that future medication fills prescribed or health care services furnished by his or her current provider will no longer be covered because the individual or entity has been placed on CMS's preclusion list, as required by 42 CFR § 417.478(e), § 422.224(b), § 460.86(b), and § 423.120(c)(6)(iv)(B)(1). After publication of the preclusion list, the Medicare plans or Part D plans should send a notice to ensure that members who have previously received a prescription or care in the last 12 months from a precluded provider receive a notice as soon as possible but no later than 30 calendar days after the publication of the associated list or update. The plan must also ensure reasonable efforts are made to notify the beneficiary's provider of a beneficiary who was sent a notice. Plans are not required to use this version for the required beneficiary notice, however, the letters should include the information specified in this model notice.]

<DATE>

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MEMBER NAME>:

This letter is to inform you that we can no longer cover [*Insert all that apply* <prescription medications> <health care items> <health care services>] for dates of service after [Effective Date Plan Claim Rejections Begin] that are [*Insert one* <prescribed > <ordered>] by <NAME OF PROVIDER>. [*Insert if applies* <This includes new prescriptions, as well as any refills left on the prescription(s) you are currently taking>].

<PLAN NAME> cannot cover [*Insert as applicable* <health care items>< health care services> <medications>] [*Insert as applicable* <provided> <ordered> <prescribed>] by <NAME OF PROVIDER> as of [Effective Date Plan Claim Rejections Begin] because he/she has been placed on a Medicare "preclusion list" by the Centers for Medicare & Medicaid Services (CMS). Medicare plans are prohibited from making payment for [*Insert as applicable* <health care items and services furnished> < prescriptions prescribed>] by individuals and entities on the preclusion list. For more information about the preclusion list, you may visit CMS's website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List.

{Plan should insert one of the two sentences below.}
[*Part C plans insert \:* Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>) if you need assistance finding another provider in your area.] [*Stand-alone Part D plans insert:* Please call 1-800-Medicare (1-800-633-4227) (TTY users should call 1-877-486-2048) if you need assistance finding another provider.] If you have further questions regarding the status of your prescription(s), we are available from <hours of operations>.

Sincerely,

<Plan Representative>

Last Updated <Date>

[Appropriate language, including disclaimers, is expected to appear in this model document.]

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