

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 (Select One: Mitigating Factors, Affirmative Defenses, Waiver Support) Approval

Date of Notice: FULL DATE

CONTACT NAME
JOB TITLE
CE NAME
ADDRESS 1
ADDRESS 2
CITY, ST ZIP

Re: Corrective Action Number **XXXXX**

Dear TITLE LAST NAME:

On (month, day, year), <**Covered Entity Name**> submitted (insert all that apply: mitigating factors, affirmative defenses, or waiver support) in response to the results of the 2024 corrective action.

We have reviewed and approved the <**Covered Entity Name**> (insert all that apply: mitigating factors, affirmative defenses, or waiver support). All Civil Money Penalties (CMP) actions will be suspended at this time; however, your record will remain in a pending status until the violations have been corrected. We will follow up with you periodically and request a Corrective Action Plan (CAP) status update. We expect your full cooperation and that <**Covered Entity Name**> will correct all violations.

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,
Michael Cimmino, Director
National Standards Group
Office of Burden Reduction and Health Informatics

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: Kevin Stewart at kevin.stewart@cms.hhs.gov .