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

Name of Sponsoring Organization: Click or tap here to enter text.

Contract Numbers: Click or tap here to enter text.

Name and Title of Person Completing Questionnaire: Click or tap here to enter text.

Date Completed: Click or tap here to enter text.

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

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

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

   ☐ Yes
   ☐ No

   If yes, do not include these enrollees in Table 3: New Enrollee Record Layout. If no, include these enrollees in Table 3: 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.**

   Click or tap here to enter text.

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

   Click or tap here to enter text.

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

   ☐ Sponsoring Organization
   ☐ Delegated Entity

5. **What types of reject codes and reject messaging are used to identify rejected claims related to the Drug Management Program (DMP)?**

   Click or tap here to enter text.

 OMB Approval 0938-1395 (Expires MM/DD/CCYY)

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