

**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 to enter a 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?**

- ☐ Yes  
☐ 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.**

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?**

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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?**

**Select Sponsoring Organization or Delegated Entity.**

- ☐ Sponsoring Organization  
☐ Delegated Entity

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

Click or tap here to enter text.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1395 (Expires 01/31/2027). This is a mandatory information collection. The time required to complete this information collection is estimated to average 701 hours per response, 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: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that 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 [part\\_c\\_part\\_d\\_audit@cms.hhs.gov](mailto:part_c_part_d_audit@cms.hhs.gov).