



# Supplement A to Data Change Request Form

Please: a.) Copy the relevant information into Section 1 from your data change request; b.) Fill out section 2 c.) Append to your data change request and submit to [CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov)

## **Section 1:**

This attachment provides supplemental information to the Centers for Medicare & Medicaid Services regarding QHP or SADP data changes requested by:

Issuer ID: \_\_\_\_\_  
State: \_\_\_\_\_  
Issuer Legal Name: \_\_\_\_\_

The changes affect the following plan IDs and templates/data elements:

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## **Section 2:**

What is the consumer/enrollee impact of the requested changes?

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How many enrollees are currently enrolled in the affected Plan IDs (and thus potentially eligible for a notification of the change or a Special Enrollment Period to change plans)?

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What steps will you take to inform or remediate with enrollees?

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Have you discussed next steps with the appropriate state agency (DOI or Consumer Protection)? If so, state the agency name and what is the result of that discussion? If appropriate, list the state contact person for follow up.

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