**Please use Company Letterhead – Letter must be emailed to** **DPOEPOCS@cms.hhs.gov** **and** **MAPDHelp@cms.hhs.gov**

**Date:** mm/dd/yyyy

The Centers for Medicare & Medicaid Services

Center for Medicare

7500 Security Boulevard, Mail Stop – C1-13-07

Baltimore, MD 21244

**RE:** EPOC Designation Letter Request for Plan [Plan Number]

**To:** CMS EPOC APPROVAL

*[Name of Plan Or Company]* requests that CMS designate the following person as the External Point of Contact (EPOC) for plan contract(s) listed below:

|  |  |
| --- | --- |
| **Full Name:** |   |
| **Mailing address:** |   |
|  |   |
|  |   |
| **Telephone Number:**  |   |
| **Email Address:**  |   |
| **Contract Number(s):**  |   |

 ***(List all contract numbers this EPOC will be responsible for.)***

As an official of [Name of company], I have the authority to designate the person identified above as the EPOC for the contract number(s) listed above. My contact information is:

|  |  |
| --- | --- |
| **Name:** |   |
| **Title:**  |   |
| **Mailing Address:**  |   |
|  |   |
|  |   |
| **Telephone Number:**  |   |
| **Email Address:**  |   |

Sincerely,

(Signature of the Company’s official, title)