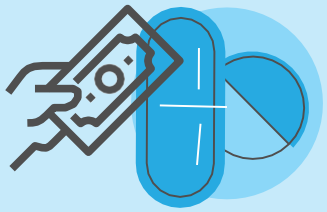
Frequently Asked Questions: Medicare Prescription Drug Inflation Rebate Program Rebate Reports



This document provides summary information to drug manufacturers about the process, deadlines, and content for Part B and Part D Medicare Prescription Drug Inflation Rebate reporting. The Centers for Medicare and Medicaid Services (CMS) refers drug manufacturers to parts 427 and 428 of title 42, Chapter IV of the Code of Federal Regulations for Medicare Prescription Drug Inflation Rebate Program Policy. CMS intends that this FAQ reflect the policies established in regulation.

CMS intends to update this list of questions and responses over time to provide information that facilitates program operations and compliance.

Questions regarding this document may be directed to InflationRebateProgram@cms.hhs.gov.

Reports

Question: What reports can I expect to receive?

Response: Manufacturers of a rebatable drug(s) covered under Medicare Part B or Part D may receive Preliminary Rebate Reports, Rebate Reports, Reconciliation Preliminary Rebate Reports, Reconciliation Rebate Reports, First Reconciliation Preliminary Rebate Reports (Part D only), First Reconciliation Rebate Reports (Part D only), Second Reconciliation Preliminary Rebate Reports (Part D only), and Second Reconciliation Rebate Reports (Part D only) (hereinafter, collectively referred to as preliminary reports, reports, and reconciliation reports).

Question: When should I expect my next Part B and Part D report(s)?

Response: Part B: For applicable calendar quarters, except applicable calendar quarters in calendar years 2023 and 2024, Rebate Reports will be sent within 6 months after the end of each applicable quarter. Preliminary Rebate Reports will be provided at least one month prior to the Rebate Reports. Reconciliation Rebate Reports will be provided within 12 months of the date of receipt of the Rebate Report for the applicable calendar quarter. Reconciliation Preliminary Rebate Reports will be provided at least 1 month before the Reconciliation Rebate Report.

Only for applicable calendar quarters in calendar year 2023 and 2024, Preliminary Rebate Reports were issued in July 2025 and Rebate Reports were provided by September 30, 2025, given the flexibility provided to CMS under section 1847A(i)(1)(C) of the Social Security Act. Applicable calendar quarters in calendar year 2023 will not undergo reconciliation, so there will be no reconciliation reports. For applicable calendar quarters in calendar year 2024, Reconciliation Rebate Reports will be provided within nine months after receipt of the Rebate Report. Reconciliation Preliminary Rebate Reports will be provided at least one month prior to the Reconciliation Rebate Report. For additional information about the reports for applicable calendar quarters in calendar years 2023 and 2024, see 42 CFR § 427.502.

Part D: For applicable periods, except applicable periods beginning October 1, 2022 and October 1, 2023, Rebate Reports will be sent within 9 months after the end of each applicable period. Preliminary Rebate Reports will be provided at least one month prior to the Rebate Reports. CMS will issue First Reconciliation Rebate Reports within 12 months of the date of receipt of the Rebate Report and will issue First Reconciliation Preliminary Rebate Reports at least one month prior to the First Reconciliation Rebate Report. CMS will issue Second Reconciliation Rebate Reports within 24 months after the date of receipt of the Rebate Report and will issue Second Reconciliation Preliminary Rebate Reports at least one month prior to the Second Reconciliation Report.

Only for applicable periods beginning October 1, 2022 and October 1, 2023, Preliminary Rebate Reports were issued in September 2025 and Rebate Reports will be provided no later than December 31, 2025, given the flexibility provided to CMS under section 1847A(i)(1)(C) of the Social Security Act. The Reconciliation Rebate Reports for the applicable period beginning October 1, 2022 will be issued within 21 months after the Rebate Report and the Reconciliation Preliminary Rebate Reports will be issued at least one month before the Reconciliation Rebate Report. For the applicable period beginning October 1, 2023, the First Reconciliation Rebate Reports will be issued within 9 months after the Rebate Report and the First Reconciliation Preliminary Rebate Reports will be issued at least one month prior to the First Reconciliation Rebate Report. For the applicable period beginning October 1, 2023, the Second Reconciliation Rebate Reports will be issued within 33 months after the Rebate Report, and the Second Reconciliation Preliminary Rebate Reports will be issued at least one month prior to the Second Reconciliation Rebate Report. For additional information about the reports for applicable periods beginning in calendar years 2023 and 2024, see 42 CFR § 428.402.

Manufacturers will receive an email notification when a preliminary report, report, or reconciliation report has been posted to the Inflation Rebate Portal in the Manufacturer Payment Portal (MPP).

Question: Where can I find information on the definitions of the columns and calculations shown in my reports?

Response: You may find data dictionaries in the "References" section of the "Medicare Prescription Drug Inflation Rebate Program" page on the MPP. A file layout for the comma-separated values (CSVs) is available on the CMS webpage for the Medicare Inflation Rebate Program.

Question: I received a preliminary report. Do I need to pay anything at this time?

Response: Preliminary reports are provided to manufacturers at least 1 month prior to the reports to facilitate the Suggestion of Error (SOE) process. There is no payment required upon receipt of a preliminary report.

Question: I received a rebate report after receiving a preliminary rebate report. Do I need to pay anything at this time?

Response: Reports act as the invoice for a manufacturer's rebate amount due, if any, and payment is due by 11:59 p.m. Pacific Time within 30 days of the date of receipt of a report (as described in 42 CFR § 427.505 and 42 CFR § 428.405).

Question: Does CMS use a rounding methodology when calculating rebate amounts owed?

Response: Values displayed in the report are rounded; however all calculations are conducted using non-rounded input values (as described in 42 CFR §§ 427.300-427.304 and 42 CFR §§ 428.200-428.204). For this reason, the rebate amount that would result if a manufacturer were

to replicate the calculations using the rounded input values displayed in the report may not match the rebate amount calculated by CMS using non-rounded input values. For example, the applicable calendar quarter specified amount and the annual manufacturer price (and most other calculated fields) are shown in reports with four decimal places, but the reduced total rebate amount is shown in reports as rounded to the nearest cent, as described in 42 CFR § 427.501(c)(3) and 42 CFR § 428.401(c)(3).[1]

Question: I did not receive a report for a drug for a given applicable calendar quarter or applicable period, but I have received one in the past. Why?

Response: Per 42 CFR § 427.501 and 42 CFR § 428.401, reports will be provided to manufacturers of Part B and Part D rebatable drugs for an applicable calendar quarter or applicable period, respectively. If a drug (or drugs) is not rebatable in an applicable calendar quarter or applicable period, the manufacturer will not receive a report for the non-rebatable drug(s) for that applicable calendar quarter or applicable period.

Question: Why did I receive a report if my drug is discontinued or terminated?

Response: Discontinued drugs may take time to exit the supply chain. It is possible that a discontinued National Drug Code (NDC) was administered and paid for by Medicare after the drug was discontinued by the manufacturer. CMS will invoice manufacturers on all units paid for by Medicare, subject to certain exclusions, as stated in 42 CFR § 427.303 and 42 CFR § 428.203. Although not expected, if a terminated drug meets the definition of a Part B rebatable drug and is administered and covered under Medicare Part B, Part B rebates would apply to these units. For further information on Part B rebates for terminated drugs, refer to page 13 of Medicare Part B Drug Inflation Rebates Paid by Manufacturers: Revised Guidance, Implementation of Section 1847A(i) of the Social Security Act. If a terminated drug meets the definition of a Part D rebatable drug and is administered and covered under Medicare Part D, Part D rebates would apply to these units. For further information on Part D rebates for terminated drugs, refer to page 12 of Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Revised Guidance, Implementation of Section 1860D-14B of the Social Security Act.

Question: Why did I receive a report if I no longer sell a drug covered under Medicare Part B or Part D?

Response: CMS identifies the Part B or Part D manufacturer, respectively, that is responsible for paying a rebate using the same approach used for reporting Average Sales Price (ASP) and Medicaid Drug Rebate Program Average Manufacturer Price (AMP) data (see 89 FR 98264 and 89 FR 98305 of the CY 2025 Physician Fee Schedule Final Rule). Manufacturers that previously reported data to the ASP Data Collection System or the Medicaid Drug Programs system associated with a drug(s) covered under Part B or Part D may still receive a report for such drugs. Part B rebates are assessed on a quarterly basis and Part D rebates are assessed on a yearly basis; reports are sent after the time period in question. If you received a preliminary report for a drug for which your company has never been responsible for reporting ASP data or Medicaid Drug Rebate Program AMP data, please email the Medicare Prescription Drug Inflation Rebate Program mailbox, InflationRebateProgram@cms.hhs.gov.

Question: My report shows that I owe $0. Why did I receive a report?

[1] The Electronic Code of Federal Regulations (eCFR) will be updated to reflect the Calendar Year 2026 Physician Fee Schedule Final Rule, which can be found here.

Response: Per 42 CFR § 427.501(c)(2) and 42 CFR § 428.401(c)(2), CMS sends reports for all rebatable drugs regardless of whether there is a rebate amount due (i.e., the rebate amount may be $0). For example, a $0 rebate amount could occur when a drug's applicable calendar quarter specified amount or annual manufacturer price (AnMP) meets all requirements to qualify for the Medicare Prescription Drug Inflation Rebate Program and does not exceed its inflation-adjusted payment amount, as described in 42 CFR § 427.302(g) and 42 CFR § 428.202(f), or if a drug had no units sold in the applicable calendar quarter or applicable period. Although a manufacturer may not owe a rebate for a drug on the report in the applicable calendar quarter or applicable period, the manufacturer may owe a rebate following reconciliation.

Question: My report contains '.' instead of an expected value. What does this mean?

Response: As mentioned in the data dictionaries in the "References" section of the "Medicare Prescription Drug Inflation Rebate Program" page on the MPP, a value of '.' indicates that the value is not applicable or is missing. For example, if a Part D rebatable drug is not a line extension, the value for "line extension initial drug" will display with a '.' because it is not applicable. Alternatively, if there is no AMP data available in the applicable period, the annual manufacturer price will display as '.' because the data is missing.

Part B Rebate Reports

Question: Why is the specified amount on my report different from the published payment limit in the applicable calendar quarter?

Response: The applicable calendar quarter specified amount is calculated for the purposes of the Medicare Prescription Drug Inflation Rebate Program and may not reflect the published payment limit in a quarter. The applicable calendar quarter specified amount is calculated as described in 42 CFR § 427.302(b), while the published payment limit may take into consideration other factors, as described here.

Question: How is the payment amount benchmark quarter assigned?

Response: The payment amount benchmark quarter is identified as set forth in 42 CFR § 427.302(c). For Part B rebatable drugs first approved or licensed on or before December 1, 2020 and marketed on or before December 1, 2020, the payment amount benchmark quarter is typically the calendar quarter beginning July 1, 2021. For Part B rebatable drugs first approved or licensed after December 1, 2020 or first marketed after December 1, 2020, the payment amount benchmark quarter is the third full calendar quarter after a drug's first marketed date. Per 42 CFR § 427.302(c)(4), for a Part B rebatable drug that was billed under a Healthcare Common Procedure Coding System (HCPCS) not otherwise classified (NOC) code during the calendar quarter beginning July 1, 2021, or the third full calendar quarter after such drug's first marketed date, whichever is later, the payment amount benchmark quarter is the third full calendar quarter after the Part B rebatable drug is assigned a billing and payment code other than a NOC code.

Per 42 CFR § 427.302(c)(5), if the data needed to calculate the payment amount in the payment amount benchmark quarter are not available, CMS will use the third full calendar quarter after a drug is assigned a billing and payment code as the payment amount benchmark quarter, no earlier than the calendar quarter beginning July 1, 2021, or the third full calendar quarter after the drug's first marketed date, whichever is later. [2]

[2] The Electronic Code of Federal Regulations (eCFR) will be updated to reflect the Calendar Year 2026 Physician Fee Schedule Final Rule, which can be found here.

Per 42 CFR § 427.302(c)(6), if a Part B rebatable drug was a former selected drug for the Medicare Drug Price Negotiation Program and is no longer considered to be a selected drug, the payment amount benchmark quarter is the calendar quarter beginning January 1 of the last year during the price applicability period with respect to the selected drug (as defined in section 1191(b)(2) of the Social Security Act). [3]

Question: Why might the payment amount benchmark quarter be earlier than the first marketed date of any of the current NDC-11s associated with the billing and payment code?

Response: Per 42 CFR § 427.302(c), the payment amount benchmark quarter is identified on the basis of the earliest first marketed date of any NDC ever marketed under any U.S. Food & Drug Administration (FDA) application under which any NDCs that have ever been assigned to the billing and payment code as of the applicable calendar quarter have been marketed. The 11-digit NDCs (NDC-11s) listed on a report reflect the NDC-11s associated with the manufacturer and billing and payment code for the applicable calendar quarter. However, the NDC-11s associated with a billing and payment code may change over time, resulting in NDC-11s with earlier first marketed dates than those currently associated with a billing and payment code.

Question: Why did I receive a report if my Part B rebatable drug was not on the Part B adjusted coinsurance list?

Response: There are differences between how CMS determines which drugs are eligible for an adjusted coinsurance under Part B and how CMS calculates inflation rebates. For example, to calculate price increases for adjusted coinsurance as described in 42 CFR § 427.201, CMS relies on published payment limits in both the payment amount benchmark quarter and the applicable calendar quarter. For inflation rebates, CMS compares the payment amount in the payment amount benchmark quarter to the applicable calendar quarter specified amount, as described in 42 CFR § 427.302.

Part D Rebate Reports

Question: My drug was approved on or before October 1, 2020 but was not marketed until later. Why did I receive a report for this drug?

Response: The payment amount benchmark period is identified according to 42 CFR § 428.202(c). For a Part D rebatable drug first approved or licensed by the FDA on or before October 1, 2021, the payment amount benchmark period is the period beginning on January 1, 2021, and ending on September 30, 2021.

Per 42 CFR § 428.202(c)(2), for a subsequently approved drug, the payment amount benchmark period is the first calendar year beginning after the drug's first marketed date.

Per 42 CFR §§ 428.202(c)(3) and 428.202(c)(4), if AMP data was not reported for the payment amount benchmark period, the payment amount benchmark period will be the first calendar year no earlier than calendar year 2021 in which there is at least one quarter of AMP reported.

Per 42 CFR § 428.202(c)(5), if a Part D rebatable drug was a former selected drug for the Medicare Drug Price Negotiation Program and is no longer considered to be a selected drug, the payment amount benchmark period is the last calendar year during the price applicability period with respect to the selected drug (as defined in section 1191(b)(2) of the Social Security Act).

[3] The Electronic Code of Federal Regulations (eCFR) will be updated to reflect the Calendar Year 2026 Physician Fee Schedule Final Rule, which can be found here.

Question: What is the difference between the "Standard total rebate amount", "Total rebate amount", "Line extension alternative total rebate amount", and "Reduced total rebate amount"?

Response: The standard total rebate amount is calculated as specified at 42 CFR § 428.201(a)(1)(i) by taking the product of the per unit rebate amount and the total number of units dispensed. The per unit rebate amount is defined at 42 CFR § 428.202, and the total number of units dispensed is defined at 42 CFR § 428.203.

The total rebate amount is calculated as specified at 42 CFR § 428.201(a) as the greater of the standard total rebate amount or line extension alternative total rebate amount (the product of the line extension alternative per unit rebate amount and the total number of units). The standard total rebate amount and the total rebate amount may or may not be the same value.

The reduced total rebate amount is the rebate amount due after applying any applicable reduction due to shortage, a severe supply chain disruption determination, or a likely to be in shortage determination, as described at 42 CFR § 428.301, 42 CFR § 428.302, and 42 CFR § 428.303.

Suggestion of Error

Question: I disagree with the amount that my preliminary report says I owe. How can I dispute the amount?

Response: Per 42 CFR § 427.503, a manufacturer of a Part B rebatable drug has the option to submit an SOE within 10 calendar days from the date of receipt of a Preliminary Rebate Report or Reconciliation Preliminary Rebate Report for any applicable calendar quarters (except those in calendar years 2023 and 2024, for which manufacturers have 30 days to submit an SOE after receipt of the Preliminary Rebate Report, per 42 CFR § 427.502). No regular reconciliation will be conducted for the rebate amount in the single Rebate Report for the applicable calendar quarters in calendar year 2023. Manufacturers will have the standard 10 calendar days to submit an SOE for the reconciliation reports for applicable calendar quarters in 2024.

Per 42 CFR § 428.403, a manufacturer of a Part D rebatable drug has the option to submit an SOE within 10 calendar days from the date of receipt Preliminary Rebate Report or a preliminary reconciliation of a rebate amount for any applicable period (except those beginning in calendar years 2022 and 2023, for which manufacturers have 30 days to submit an SOE after receipt of the Preliminary Rebate Report, per 42 CFR § 428.402). Manufacturers will have the standard 10 calendar days to submit an SOE for the reconciliation reports for applicable periods beginning October 1, 2022 and October 1, 2023.

For more information regarding the SOE process and scope for preliminary reports for Part B rebatable drugs, see 42 CFR § 427.502 and 42 CFR § 427.503. For more information regarding the SOE process and scope of preliminary reports for Part D rebatable drugs, see 42 CFR § 428.402 and 42 CFR § 428.403.

To assist with this process, an SOE Submission Aid is provided on the SOE page of the MPP and in the "References" section of the "Medicare Prescription Drug Inflation Rebate Program" page on the MPP. Please note that while multiple SOE submissions are permitted, CMS will review only the last submission at the end of the SOE submission deadline for each unique ID and each report type; please include in your last submission all drugs (billing and payment codes and NDC-11(s) or NDC-9(s)) under

your unique ID for which you are suggesting any errors.[4]

To submit an SOE for a preliminary report received via the MPP:

- Go to the MPP > Inflation Rebates > Suggestion of Error > SOE Request Tab.
- Click the 'Submit SOE' button for the specific Unique ID.
- Follow the instructions for 'Upload File'. The manufacturer is responsible for ensuring the correct file is uploaded.

Question: I do not owe any money, but I think there is a mistake in my report. Should I submit an SOE?

Response: CMS does not intend to review SOEs for a rebatable drug with an invoiced amount of $0, and does not intend to respond to SOEs for a rebatable drug with an invoiced amount of $0 (see 89 FR 98265 of the CY 2025 Physician Fee Schedule Final Rule). If you have questions about your preliminary reports or reconciliations reports, please email the Medicare Prescription Drug Inflation Rebate Program mailbox at InflationRebateProgram@cms.hhs.gov and include the applicable program (Part D or Part B), applicable rebate period or applicable rebate quarter, unique ID, labeler code, and relevant drug(s) (NDC-9(s) for Part D or billing and payment code(s) and NDC-11(s) for Part B).

Onboarding and Manufacturer Payment Portal

Question: I was contacted to onboard for the Medicare Prescription Drug Inflation Rebate Program, but I do not sell Part B or Part D drugs. What should I do?

Response: CMS is requesting that all manufacturers follow the instructions in the memo that CMS shared on November 21, 2024, as well as the follow-up manufacturer notifications sent on December 16, 2024 and March 10, 2025.

Manufacturers will be notified if they have a report for a rebatable drug through the MPP. If a drug is never deemed rebatable, taking the actions as outlined in the memo (such as creating an MPP account) will not have any impact on the manufacturer. CMS requests that all manufacturers create an account, so they are aware if they receive a rebate report for a drug in 2025 or in future years.

Question: The Medicare Prescription Drug Inflation Rebate Program contact(s) at my organization is leaving. How can I update my contact information and who can access the MPP for Medicare Prescription Drug Inflation Rebates?

Response: Manufacturers are able to update their Medicare Prescription Drug Inflation Rebate Program contacts via the CMS Health Plan Management System ("the CMS HPMS").

Note: Any user with access to the CMS HPMS is able to assign any user, regardless of whether they have access to the CMS HPMS, as a contact for the Medicare Prescription Drug Inflation Rebate Program.

Within a few weeks after a new contact is entered into the CMS HPMS, CMS' third-party administrator sends an acknowledgment/welcome letter, which provides instructions on how to access the MPP.

Question: I need to make a change to my unique ID or the labeler codes under my unique ID. How can I do so?

[4] The unique ID is the number assigned to a manufacturer by CMS for the purposes of the Medicare Prescription Drug Inflation Rebate Program. This value can either be a P number or an "L" followed by the labeler code.

Response: All manufacturers have the ability to add, terminate, or transfer labeler codes in the CMS HPMS. For more information on adding, terminating, or transferring a labeler code in the CMS HPMS, please refer to the user guide in the CMS HPMS Drug Manufacturer Contract Management module.

In addition, CMS is allowing manufacturers to separate labeler codes from their P Number only for the purposes of the Medicare Prescription Drug Inflation Rebate Program. This may occur in cases where a labeler code is associated with a P Number that does not own the entity or if there are several labeler codes associated with a P Number, and the manufacturer wishes to have different points of contact on each. Please note, depending on the time the change occurred in the CMS HPMS and the reporting cycle schedule, a labeler number may not be created until after the next report has been transmitted to manufacturers and individuals listed as P Number level contacts may receive the report. If you have any concerns with this timeline, please let the CMS team know as soon as possible. If a manufacturer would like to separate their labeler code(s) from their P Number, they must enter Medicare Prescription Drug Inflation Rebate Program contacts at the labeler code level; otherwise, the Medicare Prescription Drug Inflation Rebate Program contacts default to the P Number-level in the MPP.

Please be aware that if a P Number has only one associated labeler code and Medicare Prescription Drug Inflation Rebate Program contacts are added for both the P Number and the labeler code, then the labeler code contacts will take precedence over the P Number contacts and will be considered the Medicare Prescription Drug Inflation Rebate Program contacts of record. Therefore, it may not be necessary to enter labeler code level contacts if there is only one associated labeler code.

Question: I am unable to access the MPP to view my reports and/or submit an SOE. How can I do so?

Response: As part of your onboarding to the Medicare Prescription Drug Inflation Rebate Program you received a MPP log in and welcome letter from the Third Party Administrator (TPA) with information about how to access your account. If you have issues accessing your account, please contact the TPA help desk at 877-534-2772 or tpaoperations@tpaadministrator.com for further assistance. If you have not completed onboarding activities to gain access to the MPP, please email InflationRebateProgram@cms.hhs.gov to receive next steps about onboarding.

Question: How do I request an HPMS P Number?

Response: To request a P Number, manufacturers should email the following information to InflationRebateProgram@cms.hhs.gov:

- Manufacturer legal name
- Data Universal Numbering System (DUNS) number
- Employer Identification Number (EIN)
- Primary contact first and last name
- Primary contact email address
- Primary contact phone number

Question: If my company has an existing Part D or Part D (Generics) P Number, how do I indicate my company also manufactures Part B Drugs?

Response: To indicate that your P Number also manufactures Part B drugs, please navigate to the Drug Manufacturer Contract Management Module after logging in to the CMS HPMS. Once in the module, you will select your P Number and then select the Manage Contract Data link in the left navigation menu. To indicate that your organization also manufactures a Part B drug(s), please select "Add Program Type" and review the information in the pop up window. Click "Submit" to add the Part B Program Type to your P Number. Manufacturers may be required to complete additional data entry to activate a newly added program type.

Question: If my company has an existing Part B P Number, how do I indicate my company also manufactures Part D Generic Drugs?

Response: To indicate that your P Number also manufactures Part D Generic drugs, please navigate to the Drug Manufacturer Contract Management Module after logging in to the CMS HPMS. Once in the module, you will select your P Number and then select the Manage Contract Data link in the left navigation menu. To indicate that your organization also manufactures a Part D (Generics) drug(s), please select "Add Program Type" and review the information in the pop up window. Click "Submit" to add the Part D (Generics) Program Type to your P Number. Manufacturers may be required to complete additional data entry to activate a newly added program type.

Question: My HPMS P Number is terminated. Why do I need to request a new P Number to enter Medicare Prescription Drug Inflation Rebate contacts?

Response: CMS is requesting that all manufacturers create a new P Number to be notified should one or more of their drugs receive a report and is potentially liable for an inflation rebate due to CMS in 2025 or in future years. Your organization will need an active P Number to be able to assign Medicare Prescription Drug Inflation Rebate contacts that will be used to establish access in the MPP.

Question: How do I update my Electronic Funds Transfer (EFT) information in the MPP?

Response: The Inflation Rebate Administrator, as designated in the CMS HPMS, is the only user role that can submit EFT information.

If the EFT information needs to be updated, follow the steps below:

1. Go to the MPP Portal
2. Enter the MPP Portal credentials on the MPP Portal Login page
3. Select the "My Profile" link in the upper right corner and select a program
4. Choose "Request Payer/ Payee Account Modification"
5. Fill out the form and follow the online instructions

The designated authorized signer for each form will receive an automatically generated password after submission. TPA, who manages the MPP, will review and send the form to the authorized signer via echosign@echosign.com once approved. The authorized signer will need to use the password previously received to open the EFT form for signature.

Due to the processing time, it is imperative that the banking account verification be completed well in advance of the rebate payment deadline of 11:59 p.m. Pacific Time on the 30th calendar day from the date of receipt of the rebate report or reconciliation report as required by 42 CFR § 428.405(a) and 42 CFR § 427.505(a). To avoid processing failures which could result in a late rebate payment, manufacturers should verify banking information well ahead of payment deadlines.