[*Instructions: The FIDA-IDD Plan should use this model to alert a Participant that future medication fills prescribed, dispensed, distributed, or manufactured (as applicable) by their current provider (prescriber or pharmacy), distributor, or manufacturer will no longer be covered because the individual or entity will be or has been excluded from participating in the Medicare program based upon an OIG exclusion. As soon as the FIDA-IDD Plan knows that an individual or entity has been posted to the exclusion list, the FIDA-IDD Plan must send this notice to every Participant who has previously gotten a prescription or prescription medication either from that provider or for a medication distributed or manufactured by the excluded entity.*]

<DATE>

<PARTICIPANT NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <PARTICIPANT NAME>:

This letter is to inform you that we can no longer cover prescription medications effective <Effective Date of OIG Exclusion> that are [*insert one:* prescribed *or* dispensed *or* distributed *or* manufactured] by [*insert one:* <NAME OF PRESCRIBER> *or* <NAME OF PHARMACY> *or* <NAME OF DISTRIBUTOR> *or* <NAME OF MANUFACTURER>]. This includes new prescriptions, as well as any refills left on the prescription(s) you are currently taking.

<Plan name> cannot cover medications [*insert one:* prescribed *or* dispensed *or* distributed *or* manufactured] by [*insert one:* <NAME OF PRESCRIBER> or <NAME OF PHARMACY> or <NAME OF DISTRIBUTOR> or <NAME OF MANUFACTURER>] because they have been excluded from participation in all federal health care programs as of [*insert effective date of exclusion*], including the Medicare program, by the U.S. Department of Health and Human Services’ Office of Inspector General (OIG). Medicare plans are prohibited from making payment for prescriptions prescribed, dispensed, or furnished by excluded individuals and entities. For more information about exclusions, you may visit the OIG’s website at [oig.hhs.gov/fraud/exclusions.asp](http://oig.hhs.gov/fraud/exclusions.asp).

[*Insert at least one of the three sentences below.*]

[*Insert when applicable*: Please call your Care Manager or Participant Services at <phone number> (TTY users should call <TTY number>), <days and hours of operation>, if you need assistance finding another pharmacy.]

[*Insert when applicable*: Please call your Care Manager or Participant Services at <phone number> (TTY users should call <TTY number>), <days and hours of operation>, if you need assistance finding another provider in your area who can prescribe your medications.]

[*Insert when applicable*: Please call your Care Manager or prescriber if you need assistance finding another medication.]

If you have other questions about the status of your prescription(s), we are available [*insert day and hours of operation*].

Sincerely,

<Plan Representative>

[*The plan must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

[*The plan is subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.