*[Instructions: This model should be used by Part D sponsors to alert their members that future medication fills prescribed or dispensed by their current provider (prescriber or pharmacy) will no longer be covered because the provider is being excluded from participating in the Medicare Program based upon an OIG exclusion. This letter should be sent to the plan member as soon as the Part D sponsor has knowledge that a provider has been posted to the exclusion lists and that a member has previously received a prescription or prescription medication from that provider.]*

<DATE>

<MEMBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Dear <MEMBER 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> < dispensed>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY>]. 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> < dispensed>] by [*Insert one* <NAME OF PRESCRIBER> <NAME OF PHARMACY>] because he/she/it has been excluded from participation in all federal health care programs, 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 written or dispensed by excluded providers. For more information about excluded providers, you may visit the OIG’s website at <http://oig.hhs.gov/fraud/exclusions.asp>.

[OPTIONAL: Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>) if you need assistance finding another <pharmacy>. ] [OPTIONAL: Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>) if you need assistance finding another provider] in your area who can prescribe your medications]. If you have further questions regarding the status of your prescription(s), we are available from <hours of operations>.

Sincerely,

<Plan Representative>

<Material ID>

[<CMS Approval Date>] Last Updated <Date>

*Insert the following disclaimers:* Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, <XXXX>.

<Applicable Federal contracting disclaimer from Medicare Marketing Guidelines.>

<Phone number for beneficiary to receive material in alternate format or language>

<Material ID Number>