This report is required by law (42 USC 1395mm and 42 USC 1995l).
Failure to report can result in all interim payments made since
the beginning of the cost reporting period being deemed overpayments.

FORM APPROVED
OMB NO. 0938-0165

PREPAID HEALTH PLAN COST REPORT
GENERAL INFORMATION

WORKSHEET S

1 Name and Address of Plan:

2 Reporting Period:
From:
To:

Plan Number:
H-xxxx

3 a. Type of Report:
[ ] Budget Forecast
[X] Interim Reports
[ ] Final Cost Report

b. Bill Processing Option:
Select Option

c. Reimbursement Under:
Select Section

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OF THE PLAN

I HEREBY CERTIFY that I have examined the accompanying Statement of Reimbursable Cost, the allocation of expenses and services, and the attached Worksheets for the period from 01/00/1900 to 01/00/1900 and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the Plan in accordance with applicable instructions.

SIGNATURE (Officer or Administrator of the Plan)

DATE

TITLE

PHONE NUMBER

FORM CMS 276-19 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2302)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0165. The time required to complete this information is estimated to average as follows: (1) for HMOs/CMPs, 24 hours to complete the budget forecast, 80 hours to complete the fourth quarter and final cost reports, 4 hours to complete the semi-annual interim and 0 hours to complete the first, second, and third quarterly reports; and (2) for HCPPs, 16 hours to complete the budget forecast, 60 hours to complete the final cost report, and 4 hours to complete the semi-annual interim report. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Mail Stop C3-14-16, Baltimore, Maryland 21244-1850 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Form Expiration Date: 8/31/2022

INTERIM REPORT PART I - COSTS		PLAN NO.: H-xxxx	PERIOD FROM: 01/00/00 TO: 01/00/00	WORKSHEET C 1	
1	Hospitals				1
2	Skilled Nursing Facilities				2
3	Home Health Agencies				3
4	Other Providers				4
5	Non-Providers				5
6	Plan Administration				6
7	Special Administrative Costs				7
8	Administrative and General				8
9	Total Costs (Sum of lines 1 thru 8)			-	9
10	Cost per Member-Month (Line 9 divided by Part II, Line 1)			-	10
11	Applicable Projection ratio from budget forecast (Worksheet A, Part V, Column 2, Line 2)				11
12	Medicare costs (Line 10 times Line 11)			-	12
13	Payment Rate (Line 12 times Line 5 of Part II)			-	13
14	Current Payment Rate				14

PART II - MEMBERSHIP		PART B 1	
1	Total Member Months		1
2	Total Medicare Member-Months		2
3	Medicare Member-Months (Secondary)		3
4	Medicare Member-Months (Primary)	-	4
5	Ratio (Line 4 divided by Line 2)	0.0000	5

FORM CMS 276-19 (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2305 - 2305.3)