<DATE>

Exclusion
Correction Notice

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MEMBER NAME>:

Our records indicate that you either received information from <PLAN NAME> that future medication fills [*insert one* <prescribed by NAME OF PRESCRIBER> <filled by NAME OF PHARMACY>] will no longer be covered because the provider was being excluded from participating in the Medicare Program, or you recently attempted to fill or refill [*Insert one* <a prescription> <prescriptions>] and [*Insert one*<it> <they>] [*Insert one* <was> <were>] denied for the same reason.

[Insert one]

[OPTION 1: The purpose of this letter is to inform you that [NAME OF PRESCRIBER OR PHARMACY>] was incorrectly identified as a provider excluded from participating in the Medicare program. Our records have now been corrected. <NAME OF PRESCRIBER OR PHARMACY>] is not excluded from participating in Medicare. <PLAN NAME > sincerely apologizes for any inconvenience this error may have caused you.

[OPTION 2: The purpose of this letter is to inform you that <NAME OF PRESCRIBER OR PHARMACY> is no longer excluded from participating in the Medicare program as the <DATE>].

[*If prescription has been filled insert* <This error affected the following prescription(s) :> <List affected prescription names>]

[If applicable, insert one]

[OPTION 1: We have contacted <NAME OF PHARMACY> regarding your initially denied prescription(s). The pharmacy advised us that, on <date>, the prescription(s) [*insert one* <was><were>] filled and processed successfully using your Medicare plan.]

[OPTION 2: We have contacted <NAME OF PHARMACY> regarding your denied prescription(s). The pharmacy advised us that the prescription(s) [*insert one* <was><were>] filled on <date> but not processed through your Medicare plan. Please use the enclosed form and submit it with your receipt to <PLAN NAME> if you wish to make a claim for reimbursement under your Medicare plan.]

[OPTION 3: We have contacted <NAME OF PHARMACY> regarding your denied prescription(s). The pharmacy advised that the prescription(s) was not filled. However, if you have any prescriptions that you purchased out-of-pocket after <Effective Date of Incorrect OIG Exclusion or of OIG Reinstatement>, please use the enclosed paper claim form to submit for processing and reimbursement.]

[OPTION 4: You may now have your medications [*insert one:* <prescribed by NAME OF PRESCRIBER> <filled by NAME OF PHARMACY>.]

If you have further questions regarding the status of your prescription(s), we are available from <hours of operations>. Please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>.

Sincerely,

<Plan Representative >

[OPTIONAL: Enclosure: Prescription Drug Claim form]
<Material ID>
[<CMS Approval Date>] Last Updated <Date>