Part D Complaint Casework Checklist

Beneficiary Name: ________________________________

Medicare Number: _______________ **Plan:** ______________________

Caller Name: _________________________ **Telephone Number:** _____________

Address: ____

Date of Incident: ______________________

ATTACH A MARx SCREEN PRINT

Is the call about:

Charged too much co-payment:

LIS in system Y N
Beneficiary has letter of approval from SSA: Y N Unk
Date of approval: _________________

Unable to fill prescription
LIS or dual Y N

Is the pharmacy in the network Y N Unk

Is the drug on the formulary Y N Unk

When did you enroll in the plan _____________________

Is this a refill or a new prescription Refill New

Plan's Customer Service

Describe problem:

Long hold time Call dropped Other:______________
Other

Please describe: ____

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____

____

Name of Drugs (and amount paid) Beneficiary is trying to fill:

____

____

Call received by: _____________________ **Date:** ________________________

Email to: PartDComplaints_RO4@cms.hhs.gov