

Medicare Prescription Drug Coverage Part D

Complete the following information for each Type of Coverage offered by the Entity/Plan Sponsor:

Name of Entity Offering Coverage Lutheran Augustana Center		
Entity Federal ID Number	<input type="text"/>	ex: xx-xxxxxxx
Street Address of Entity 5434 Second Avenue		
City	Brooklyn	State NY Zip Code
	11220	
Phone Number of Entity	<input type="text"/>	ex: xxx-xxx-xxxx
Type of Coverage (Choose One):		
GROUP HEALTH PLAN:		
<input checked="" type="radio"/> Employer Sponsored Plan Please check this option & continue below		
<input type="radio"/> Union/Taft Hartley Sponsored Plan		
<input type="radio"/> Church		
<input type="radio"/> Federal Government		
<input type="radio"/> State Government		
<input type="radio"/> Local Government		
<input type="radio"/> Other Entity		
STATE-SPONSORED PLANS:		
<input type="radio"/> Medicaid		
<input type="radio"/> State Pharmacy Assistance Program (SPAP)		
<input type="radio"/> State High Risk Pool		
<input type="radio"/> Other State-Sponsored Plan: <input type="text"/>		
MEDIGAP (Medicare Supplement) PLAN (as defined under S403.205):		
<input type="radio"/> Standardized Plan (H, I, J)		
<input type="radio"/> Pre-standardized Plan		
<input type="radio"/> Waiver State Plan		
<input type="radio"/> Innovative Benefit Rider		
<input type="radio"/> INDIVIDUAL HEALTH INSURANCE (Non-Medigap Plans)		
<input type="radio"/> VETERANS COVERAGE (under Chapter 17 of Title 38 U.S.C.)		
<input type="radio"/> MILITARY COVERAGE (under Chapter 55 of Title 10, U.S.C., including TRICARE)		
<input type="radio"/> INDIAN HEALTH SERVICE		
<input type="radio"/> TRIBE OR TRIBAL ORGANIZATION		
<input type="radio"/> URBAN INDIAN ORGANIZATION		
<input type="radio"/> OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS Please Fill in Type of Plan: <input type="text"/>		

How many Prescription Drug Options offered under this Coverage?

Please Select One of the following and an additional box will appear for you to complete the required disclosure information.

- All Options Offered Are Creditable **Please check this option & continue below**
- All Options Offered Are Non-Creditable
- There are some Creditable or Non-Creditable Options Offered.

You have selected	<input type="text" value="All Options Offered Are Creditable"/>
Period covered by this Disclosure:	
■ Plan Year Beginning Date	<input type="text" value="01/01/2010"/> Plan Year Ending Date <input type="text" value="12/31/10"/>
■ Number of Part D Eligible Individuals expected to be covered under these Option(s) as of the Plan Year Beginning Date stated above:	<input type="text"/>
■ Estimated number of those individuals expected to be covered through an Employer or Union Retiree Group Health Plan	<input type="text"/>
■ Date the of Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the entity (MM/DD/YYYY)	<input type="text" value="10/20/2009"/>
■ Is this a change to a previous disclosure of Creditable Coverage status provided to CMS?	
Yes <input type="radio"/> No <input checked="" type="radio"/>	
■ If yes, include the effective date(s) of this change (MM/DD/YYYY)	<input type="text"/>
■ Date Entity completed the disclosure to Part D Eligible Medicare Individuals of this change in Creditable Coverage (MM/DD/YYYY)	<input type="text"/>

I understand and agree to the following statements:

- That this submission supersedes any previous submission of this information with dates prior to the date below;
- That the entity/plan sponsor agrees to disclose to CMS and all Medicare Part D eligible individuals any changes that would affect the creditable status of above coverage as outlined under S 423.56.
- That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
- That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

<input type="text"/>	<input type="text"/>
(Name of Entity's Authorized Individual)	(Title)
<input type="text"/>	<input type="text"/>
(Email of Entity's Authorized Individual)	Date (MM/DD/YYYY)