SAMPLE
FAX/MAIL Cover Sheet
Centers for Medicare & Medicaid Services (CMS)
Medicare Prescription Drug Plan Enrollment Information Request

Date: ______________________

I AM (check one)

☐ **FAXING this information to Medicare at 785-830-2593**

☐ **MAILING this information to Medicare Nursing Home Requests, 3833 Greenway Drive, Lawrence, KS 66046-5504**

Please provide Medicare with the following information :

Your Contact Name: ____
Your Contact Phone # :____
Your Overnight Delivery Address (No PO Boxes):
Address: ____
City/State/Zip____
Total Number of Pages (Please number each page): _________________
Identification:
Institution Name:____
Medicare Billing Number:____________________________________

Attestation:
I attest that the Medicare Prescription Drug Plan enrollment information to be provided by the Centers for Medicare & Medicaid Services (CMS) will be used by the nursing home only for Medicare prescription drug coverage purposes.

____
Signature of Nursing Home Representative

The attached/enclosed information is CONFIDENTIAL and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution, or copying of the communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone and return the original message to us at the address above via U.S. Mail. Thank you.