

## Fax Cover Sheet

### CMS Medicare Prescription Drug Plan Enrollment Information Request

Date: \_\_\_\_\_

Facility Fax Number: Area Code ( ) \_\_\_\_\_

Voice Contact Name: \_\_\_\_\_

Voice Contact Phone #: \_\_\_\_\_

Number of pages (including cover sheet): \_\_\_\_\_

Identification:

Institution Name: \_\_\_\_\_

Medicare Billing Number: \_\_\_\_\_

Comments:

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 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.*

**Fax request to Medicare at (785)-830-2593.**