FIR Transaction History Request

Plan Name of submitter	
Contact Name of submitter	
Contact phone of submitter	
Contact email of submitter	

Part D Plan Demographics	
Contract ID	
BIN	
PCN	
Group	
Plan Year	
Processor/PBM as of plan year requested	

*Note: leading zeros are important so make sure that all characters used are written above

Reason for request (i.e. audit, member inquiry)

Description of work

Please submit the HICNs via a secure email in a password protected document due to protected health information (PHI). The password should be sent in a separate email.

Data elements to be returned and report format
Return the following fields: In (name format) is it excel or CSV???

A copy of this request (this completed document only) will be provided to CMS at completion of the work, per CMS requirements.

_____   _____   _____

Requestor signature   Printed Name   Date

CMS coverage/Commercial service (to be completed by CMS)