



### Medicare Coverage Gap Discount Program

#### Civil Money Penalty Payment

**\*Required Fields**

**\*Manufacturer P Number:**

**\*Manufacturer Name:**

**\* Address:**

**\* City:**

**\* State:**

**\* Zip Code:**

**\*Point of Contact Name:**

**\*Point of Contact Phone:**

**\*Point of Contact Email:**

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**\*Date of Demand Letter:**

**Invoice Quarter for which Penalties are due:**

**\*Quarter:**

**\*Year:**

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**\*Payment Amount: \$**

(Note: This must be the total amount due)

Submit Data