Blue MedicareRx (PDP)

Connecticut | Massachusetts | Rhode Island | Vermont

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: _____

Enrollee Name: _____

Address: _____

_____

Phone: _____

Medicare Health Insurance Claim #:
(from red, white and blue Medicare card)

_____

Name of Medicare Prescription Drug Plan:

_____

Please check all boxes that apply to you.	**Dates of Coverage (month/year)**
☐ I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP) Name:_____	From: _____ To: _____
☐ I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state Name of SPAP:_____ If you are in an SPAP, what state do you live in: _____	From: _____ To: _____
☐ I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits)	From: _____ To: _____
☐ I had prescription drug coverage through my TRICARE or other military coverage	From: _____ To: _____
☐ I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage	From: _____ To: _____

* "Creditable" means that your prior coverage met Medicare's minimum standards.

☐ I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U)	From: _____ To: _____
☐ I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly)	From: _____ To: _____
☐ I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____	From: _____ To: _____
☐ I have/had extra help from Medicare to pay for my prescription drug coverage.	From: _____ To: _____
☐ I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: _____	From: _____ To: _____
☐ I never had creditable* drug coverage	

Please complete this section: "To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Blue MedicareRx (PDP) or by Medicare."

Signature: _____

Date: *(month/day/year):* _____/_____/_____

If you are the representative, you must provide the following information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee: _____

Blue MedicareRx (PDP) is a Prescription Drug Plan with a Medicare Contract. Blue MedicareRx Value Plus (PDP) and Blue MedicareRx Premier (PDP) are two Medicare Prescription Drug Plans available to service residents of Connecticut, Massachusetts, Rhode Island, and Vermont. Coverage is available to residents of the service area or members of an employer or union group and separately issued by one of the following plans: Anthem Blue Cross® and Blue Shield® of Connecticut, Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.