SilverScript Choice (PDP)
PO Box 52066
Phoenix, AZ 85072-2066

FirstName LastName
Address1
Address2
City, State ZipCode

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed under the section titled “Get help & more information.”

P.O. Box 52066
Phoenix, AZ 85072-2066
1-866-235-5660

NOTICE OF DENIAL OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Date: 01/03/2022	
Enrollee's Name: FirstName LastName	Member Number: Test Member ID 362

Your request was denied
We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested: PREDNISONE TAB 10MG; COMBIGAN SOL 0.2/0.5%

Why did we deny your request?
We denied this request under Medicare Part D because:

PREDNISONE TAB 10MG; COMBIGAN SOL 0.2/0.5%

- We were unable to approve your request for reimbursement because our records indicate that the prescription drug(s) submitted with the request were previously processed through your Plan benefit, and that appropriate copays and deductibles have been applied. Your claim paid appropriately at time of processing, therefore no additional reimbursement will be provided. If you have secondary insurance, please submit your reimbursement request to your secondary insurance provider. If you would like us to reconsider our decision, you may file an Appeal. More information about submitting an appeal may be found below. If you have questions or need assistance, please call the toll-free number on your Prescription Benefit ID card.

You should share a copy of this decision with your prescriber so you and your prescriber can discuss next steps. If your prescriber requested coverage on your behalf, we have shared this decision with your prescriber.

What If I Don’t Agree With This Decision?
You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a **formulary exception** if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a

rule such as prior authorization or a quantity limit should not apply to you. You can either provide information that shows that you meet the coverage rule that applies to the drug you are requesting or you can ask for a coverage rule exception. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at: 1-866-235-5660 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY: 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- ☐ **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- ☐ If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If your appeal is for payment of a drug you've already received, we'll give you a written decision within 14 days.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. Remember, your doctor must provide us with a supporting statement if you're requesting an exception to a coverage rule. You should include information about why the coverage rule should not apply to you because of your specific medical condition. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited (Fast) Appeal: You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by mail. **A verbal request by telephone is the fastest way to file an expedited (fast) request.**

Phone: 1-866-235-5660

TTY: 711

For a Standard Appeal: You, your prescriber, or your representative can file an appeal by telephone, by fax, through the plan's website, or by sending a letter to the mailing address listed below.

Phone: 1-866-235-5660

TTY: 711

Fax: 1-855-230-5549

Plan Website: www.aetnamedicare.com

Address: SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department
P.O. Box 52066
Phoenix, AZ, 85072-2066

What Happens Next?
If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Get help & more information

- SilverScript Choice (PDP) Toll Free: 1-866-235-5660
  TTY users call: 711
  24 hours a day, 7 days a week
  www.aetnamedicare.com
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week.
  TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050 (1-888-466-9050)
- Elder Care Locator: 1-800-677-1116
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0976. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have

any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

P.O. Box 52066
Phoenix, AZ 85072-2066
1-866-235-5660

Request for Redetermination of Medicare Prescription Drug Denial

Because we, SilverScript Choice (PDP), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
SilverScript Insurance Company Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52066
Phoenix, AZ 85072-2066

Fax Number:
1-855-230-5549

You may also ask us for an appeal through our website at www.aetnamedicare.com. Expedited appeal requests can be made by phone at 1-866-235-5660, TTY: 711, 24 hours a day, 7 days a week.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare, 24 hours a day, 7 days a week. TTY users call: 1-877-486-2048

Prescription drug you are requesting:

Name of Drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes": Date purchased: _____ Amount paid: $_____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. (if you have a supporting statement from your prescriber, attach it to this request).**

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

_____

_____

_____

_____

Signature of person requesting the appeal (the enrollee, or the representative):

_____ **Date:** _____

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call Customer Care at the number on your benefit ID card (TTY: 711).

Español	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio al cliente al número telefónico que aparece en su tarjeta de identificación de beneficios (TTY: 711).
中文	請注意：如果您使用繁體中文，您可以獲得免費的語言協助服務。請撥打您福利身份卡 (Benefit ID Card) 上的電話號碼 (TTY: 711) 致電客服中心。
Tiếng Việt	CHÚ Ý: Nếu bạn nói Tiếng Việt, chúng tôi có cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi cho Ban Chăm Sóc Khách Hàng theo số điện thoại có trên thẻ nhận dạng phúc lợi của bạn (TTY: 711).
한국어	알림: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본인의 혜택 ID 카드에 표시된 고객 지원 전화번호로 연락 주시기 바랍니다 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Customer Care sa numero ng telepono na nasa iyong ID card ng benepisyo (TTY: 711).
Русский	ВНИМАНИЕ! Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Свяжитесь с Отделом обслуживания клиентов по номеру телефона, указанному на вашей индивидуальной карте для социальных выплат (телетайп: 711).
العربية	**ملحوظة**: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل بفريق دعم العملاء على الرقم الموجود على بطاقة التعريف. (رقم جهاز TTY للصم: 711).
Haitian Creole	ATANSYON: Si w pale Haitian Creole, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Kliyan nan nimewo telefòn ki sou kat ID avantajou an (TTY: 711).
Français	ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Service client au numéro de téléphone figurant sur votre carte de prestations (ATS : 711).
Polski	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy w tym języku. Zadzwoń do Biura Obsługi Klienta, korzystając z numeru podanego na Twojej karcie identyfikacyjnej (TTY: 711).
Português	ATENÇÃO: se você fala português, também pode obter informações sobre os serviços de assistência nesse idioma, sem nenhum custo adicional. Ligue para o Atendimento ao Cliente usando o número de telefone no seu cartão de beneficiário (TTY: 711).
Italiano	ATTENZIONE: Nel caso in cui la lingua parlata sia l'italiano, sono disponibili gratuitamente servizi di assistenza linguistica. Contattare l'Assistenza Clienti al numero che compare sulla propria tessera dei benefit identificativa (TTY: 711).
Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Kundenbetreuung unter der Rufnummer auf Ihrer Versicherungskarte an (TTY: 711).
日本語	注：日本語での会話を希望される場合は、無料の言語支援をご利用いただけます。保険カードに記載されているカスタマーケアの電話番号(TTY: 711)へお問い合わせください。
فارسی	**توجه:** اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. از طریق شماره تلفن درج‌شده بر روی کارت شناسایی مزایای تان با بخش پشتیبانی مشتریان تماس بگیرید (TTY: 711)
हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके बेनिफिट आईडी कार्ड पर दिए गए ग्राहक सेवा के फोन नंबर पर कॉल करें (TTY: 711)।
Հայերեն	ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա ձեզ կարող են տրամադրվել թարգմանչի ծառայություններ: Զանգահարեք Հաճախորդների սպասարկման բաժին ձեր նպաստների անհատական (ID) քարտի վրա նշված հեռախոսահամարով (TTY: 711).
ગુજરાતી	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. તમારા બેનીફિટ આઈડી કાર્ડ ઉપરના ફોન નંબર પર કસ્ટમર કેરને કોલ કરો (TTY: 711).
Hmoob	MLOOG ZOO: Yog koj hais lus Hmoob, peb muaj neeg txhais lus, pub dawb rau koj. Hu rau Cov Neeg Pab Qhua Lag Luam ntawm tus xov tooj nyob hauv koj daim ID siv qhov kev pab no (Rau cov neeg hais tsis tau lus thiab tsis nov lus siv tus xov tooj (TTY: 711).
اردو	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی معاونت کی خدمات مفت میں دستیاب ہیں- اپنے منفعت آئی ڈی کارڈ پر فون نمبر (ٹی ٹی وائی: 711) پر کسٹمر کیئر کو کال کریں-
ខ្មែរ	យកចិត្តទុកដាក់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាកម្មជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ សូមទូរស័ព្ទទៅផ្នែកថែទាំអតិថិជនតាមលេខទូរស័ព្ទនៅលើប័ណ្ណ ID អត្ថប្រយោជន៍របស់អ្នក (TTY: 711)។

ਪੰਜਾਬੀ	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਬੈਨੀਫਿਟ ਆਈਡੀ ਕਾਰਡ ਉੱਪਰ ਦਿੱਤੇ ਗਏ ਕਸਟਮਰ ਕੇਅਰ ਦੇ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾੱਲ ਕਰੋ (TTY: 711)।
বাংলা	লক্ষ্য করুনঃ আপনি যদি বাংলা ভাষায় কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। কাস্টমার কেয়ারে ফোন করুন আপনার বেনিফিট আইডি কার্ডে দেওয়া (TTY: 711) নম্বর অনুযায়ী।
אידיש	אויפמערקזאם: אויב איר רעדט אידיש, זענען אוועילעבל פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט קאסטומער קעיר אויפן טעלעפאן נומער וואס איז אויף אייער בענעפיט ID קארטל (TTY: 711).
አማርኛ	ማስታወሻ:- የአማርኛ ቋንቋ ተናጋሪ ከሆኑ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዙዎት ተዘጋጀተዋል። በጥቅማጥቅም ካርድዎ ላይ በሚገኘው ስልክ ቁጥር ለደንበኞች አገልግሎት ይደውሉ (መስማት ለተሳናቸው:- 711)።
ภาษาไทย	**หมายเหตุ: ถ้าคุณพูดภาษาไทย เรามีบริการให้ความช่วยเหลือทางด้านภาษาให้คุณฟรี โทรหาฝ่ายบริการลูกค้าที่หมายเลขโทรศัพท์ที่ระบุอยู่บนบัตรผลประโยชน์ของคุณ (โทร: 711)**
Oroomiffa	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Karaa lakkoosfa bilbila Kunuunsaa Maamiltootaa waraqaa eenyummaa faayidaa kee irratti argamu (TTY: 711) tiin bilbili.
Ilokano	Pakdaar: No agsasao ka ti Ilocano, dagitti serbisyo nga tulong iti lengguahe nga libre, ket sidadaan para kenka. Tawagan ti Customer Care iti numero ti telepono iti ID card ti benepisyom (TTY: 711).
ພາສາລາວ	ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ແກ່ທ່ານ. ໃຫ້ໂທຫາຝ່າຍດູແລລູກຄ້າຕາມເບີໂທທີ່ລະບຸໄວ້ຢູ່ໃນບັດຜູ້ໄດ້ຮັບຜົນປະໂຫຍດຂອງທ່ານ (ໂທ TTY: 711).
Shqip	KUJDES: Nëse flisni Shqip, shërbimet e asistencës gjuhësore janë në dispozicionin tuaj, pa pagesë. Telefononi Kujdesin për Konsumatorët në numrin e telefonit në kartën tuaj të identifikimit të benefiteve (TTY: 711).
Srpsko-hrvatski	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite službu koja brine o korisnicima na broju telefona koji se nalazi na vašoj ID kartici usluga (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Українська	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте у Відділ обслуговування клієнтів за номером, вказаним на вашій індивідуальній карті для соціальних виплат (Телетайп: 711).
नेपाली	ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंको लागि नि:शुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको बेनिफिट आइडी कार्डमा भएको ग्राहक स्याहारको फोन नम्बर (TTY: 711) मा फोन गर्नुहोस्।
Nederlands	AANDACHT: Als u Nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel de Klantenservice op het telefoonnummer op uw id-voordeelkaart (TTY: 711).
unD	ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီကျိာ် ဒုးယိ, နမၤန့်ါ ကျိာ်တၢ်မၤစၢၤတဖဉ်, လၢတလၢာ်ဘူဉ်လာ်စ့ၤသ့နှဉ်လီၤ. ကိးတ့ါက ့်ထွဲပှၤစူးကါတၢ်ဖိ ဝဲနီဉ်ဂ့ၢ်လၢဒုးခိဉ်လၢနတၢ်နှ့ါဘျူး ID ခးကွးဒုလီၤ (TTY: 711) တက့ၢ်.
Gagana Sāmoa	FA'AALIGA: Afai e te tautala Fa'aSamoa, o lo'o avanoa le fesoasoani mo le gagana mo oe, e leai se totogi. Telefoni atu i le Tautua mo le Lautele (Customer Care) i le numera o le telefoni o lo'o i lau pepa ID (TTY: 711).
Kajin Ṃajōḷ	LALE: Ne kwoj konono kajin Majol, komaron in bok jipan ko ilo kajin ne am ejelok wonaan. Kirlok ro rej bok eddo im ej walok ilo ID kaat in jiban eo am (TTY: 711).
Română	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică gratuite. Sunați la Relații Clienți la numărul de telefon de pe cardul dvs. de benficii (TTY: 711).
Foosun Chuuk	MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei áninisin chiakku, ese kamo. Kopwe kokkori nampan Ánisi Chon Fiti won epekin om we taropwen esisinnan chon fiti. (TTY: 711).
Tonga	TOKANGA'I MAI: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'e totongi, pea teke lava 'o ma'u ia. Telefoni mai 'i he numera 'i he funga 'o ho'o kaati ID 'aonga (TTY: 711).
Bisaya	ATENSYON: Kung Cebuano imong sinultihan, adunay libreng serbisyo tabang sa lingguwahe nga imong magamit. Tawagi ang Customer Care ang numero ana-a sa imong benepisyong ID kard. (TTY: 711).
Ikirundi	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona Serivisi y'Ubudandaji kuri izi numero za terefone ku nyungu za karangamuntu yawe (TTY: 711).
Kiswahili	KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata huduma za lughabila malipo. Piga simu kwenye Kituo cha Huduma kwa Wateja kupitia nambari ya simu iliyo nyuma ya kadi yako ya kitambulisho cha kupata manufaa (TTY: 711).

Bahasa Indonesia	PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi Layanan Pelanggan di nomor telepon yang tertera pada kartu ID manfaat Anda (TTY: 711).
Türkçe	DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. Sosyal Yardım Kimlik kartınızdaki telefon numarasından Müşteri Hizmetlerini arayın (TTY: 711).
کوردی	. ئاگاداری :ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی بۆ تۆ بەردەستە. پەیوەندی بە چاودێری بەکار بکە لە ڕێگەی ژمارەی سەر ناسنامەی سوودت (TTY: 711)
తెలుగు	శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగుభాష మాట్లాడుతున్నట్లయితే, మీకు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. మీ బెనిఫిట్ ఐడి కార్డ్ పై ఉన్న నంబరు వద్ద (TTY: 711) కస్టమర్ కేర్‌కు కాల్ చేయండి
Thuɔŋjaŋ	PIŊ KENE: Na ye jam në Thuɔŋjäŋ, ke kuɔny yenë kɔc waar thok atö kuka lëu yök abac ke cïn wënh cuatë piny. Cɔl rän töŋ dë kɔc kë luɔi ye kɔc kuɔny në akuën dën tö në I.D Kat du yic (TTY: 711).
Norsk	MERK: Hvis du snakker norsk er gratis språkhjelptjenester tilgjengelige for deg. Ring kundeservice på telefonnummeret som står på fordels-ID-kortet (TTY: 711).
Català	ATENCIÓ: Si parleu català, teniu disponible un servei d'ajuda lingüística sense cap càrrec. Truqueu a Atenció al client al número de telèfon que apareix en la vostra targeta d'identificació de beneficis (TTY: 711).
Ελληνικά	Προσοχή: Εάν μιλάτε Ελληνικά, υπάρχει δωρεάν διαθέσιμη υπηρεσία γλωσσικής υποστήριξης. Καλέστε το Κέντρο Υποστήριξης Πελατών στο τηλέφωνο που αναγράφεται στην Κάρτα σας προνομίων μέλους (TTY: 711).
Igbo asusu	NRỤBAMA: Ọ bụrụ na ị na asụ Ibo, ọrụ enyemaka asụsụ, bụ n'efu, dịịrị gị. Kpọọ Onye Ntuziaka na nọmba dị na kaadị NJ elele gị (TTY: 711).
èdè Yorùbá	Akiyesi: Bí o bá nsọ èdè Yoruba, iṣẹ́ ìrànlọ́wọ́ nípa èdè, láì sanwó, wà fún ọ. Pe Olùtọ́jú Oníbàárà lórí nọ́mbà ẹ̀rọ ìbánisọ̀rọ̀ ori káàdì ìdánimọ̀ alánfààni rẹ (TTY: 711).
Lokaiahn Pohnpei	Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Ma komw anahne sawas ah komw kak call nembe me mih ni sapwelmwomi Benefit ID card. (TTY: 711).
Deitsch	Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die Englisch Schprooch. Ruf selli Nummer uff: Ruf die Leit bei Customer Care uff unnich die Namber as uff dei Benefit-ID-Card is. (TTY: 711).
ʻŌlelo Hawaiʻi	E kaulona mai: Inā ʻōlelo Hawaiʻi ʻoe, aia hoʻi nā lawelawe 'ōlelo, manawaleʻa hoʻi kēia no ʻoe. Kelepona mai i ka helu i luna o kāu pepa ola no ke kōkua iā ʻoe (TTY: 711).
Adamawa	MAANDO: To a waawii Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddir hakkilanooɓe limngal gonngal dow kaatiwol ID maaɗa (TTY: 711).
tsalagi gawonihisdi	ᎣᏍᏓᏅᏗ: ᎢᏳᏃ ᏣᏬᏂᎭ (ᏣᎳᎩ), ᏍᏉᏂᎯᏍᏗ ᎤᏬᏝᏍᏚᏗ ᎢᏳᎾᏛᏁᏗ, D49 ᎠᎴᏍᏗ ᏧᎬᏢᏗ ᏜᎩ ᏒᏩᏍᏛᎢᏍᏓᏁᎯᎢ. ᎤᏂᏩᏍᏓ ᏧᎾᏍᏓᏍᏗᏁᏗ ᏫᏥᎯᏓᏩᏛᏏ ᎾᏍᏓ ᏗᏎᏍᏗ ᏥᏍᎦᏡᏢ ID ᎠᏆᏥᏍᏗ ᏀᏙᏢ ᏰᏝ (TTY: 711).
I linguahén Chamoru	ATENSIÓN: Yanggen un tungo' I fino' Chamorro, i setbision lengguahi gaige para hagu dibatde ha. Agang i Ayudan Taotao gi numero gaige gi benefisiun ID kart-mu (TTY: 711).
ܣܘܪܝܝܐ	امبخلتا: اخني همزيمخ سورث اين ايلا بلاش. مخبرو رقم ديا ليا بطاقة مساعدة ديا. (لاشمي ولامصوثي (TTY: 711)(١٨٠٠٨٦٣٥٤٨٨
မြန်မာ	သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ သင့် အကျိုးပြုအိုင်ဒီကတ်ရှိ ဖုန်းနံပါတ် (TTY: 711) ဖြင့် ဖောက်သည်ဂရုပြုမှုကို ဖုန်းခေါ်ပါ။
Diné Bizaad	Díí baa ako' nínízíndoo. Diné Bizaad bee yá níłti' go, t'áá jii k'eh ná hóló, saad bee niká' a' ałyeedigíí. Koji' hó díił niih. (TTY: 711).
Ɓàsɔ́ɔ̀-wùɖù -po-nyɔ̀	Dè ɖùǔ dyi nɔ̀mɔ̀ dyíin cáo: Ɔ jǔ ké m̀ dyi Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓéìn m̀ gbo kpáa. Sébél nsiŋga i Téda Nsòmb i yé ntilgaga i kat yòŋ yéŋè (TTY: 711).
Chahta	ANUMPA PA̱ PISAH: Chahta illa ish anumpuli hokma̱, kvna kia Na Anumpa ya̱ peh pilla ho̱ chi̱ tohshola hinla. Chi na halbena holisso iskitini ma̱ holhtena yvt takanli mak o̱ itatoba ahalaia ya̱ I̱ paya. (TTY: 711).
Somali	DIGNIIN: Haddii aad ku hadasho Soomaali, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Ka wac Daryeelka Macmiilka lambarka ku yaalla kaarkaaga aqoonsiga ee dheeftaada (TTY: 711).