PacificSource Medicare

PacificSource Community Health Plans
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Medicare.PacificSource.com

Prior Prescription Drug Coverage Worksheet

Note: This Worksheet is optional and will not affect your ability to enroll with PacificSource Medicare.

Date:	First Name:	MI:	Last Name:

☐ I never had creditable drug coverage. (Creditable coverage means that your prior coverage met Medicare's minimum standards.)

☐ I received/receive my creditable prescription drug coverage from the source(s) checked below (check all that apply): My dates of coverage are:

☐ State-sponsored Plan, including Medicaid, State Pharmaceutical Assistance Program (SPAP), or State-High-Risk Pool from (mm/yy):_____ to (mm/yy):_____

☐ Employer/Union, including the Federal Employees Health Benefits Program (FEHBP) Name:_____ from (mm/yy):_____ to (mm/yy): _____

☐ Veterans, survivor, or dependent benefits (VA) and/or military coverage, including TRICARE from (mm/yy):_____ to (mm/yy):_____

☐ A Medigap (Medicare Supplemental) policy with drugs from (mm/yy):_____ to (mm/yy):_____

☐ Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U) From (mm/yy):_____ to (mm/yy):_____

☐ PACE organization from (mm/yy):_____ to (mm/yy):_____

☐ Other source:_____ From (mm/yy):_____ to (mm/yy):_____

☐ I received extra help from Medicare to pay for my prescription drug coverage in 2012/2013. (Circle the year(s) that apply.)

☐ I received a letter from Medicare stating that my penalty was reduced or "reconsidered." Date of letter (mm/yy): _____

☐ 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:_____ (Check this box even if you joined a Medicare drug plan in 2006, but your drugs weren't covered until January 1, 2007. The list of parishes and counties that FEMA declared eligible for "individual assistance" because of Hurricane Katrina can be found at: www.fema.gove/news/disasters.fema?year=2005.)

Please read the following sections:

To the best of my knowledge, the information on this form is true and correct.

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: this person is authorized under State law to complete this enrollment.

Signature:_____Date:_____

Relationship to beneficiary: ☐ Self ☐ Authorized Representative ☐ Other _____

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

Name: _____

Address: _____

Phone Number: _____ Relationship to Enrollee: _____

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal.

PacificSource Community Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource Community Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 863-3637, TTY: (800) 735-2900.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
(888) 863-3637, TTY: (800) 735-2900。