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: _____
☐ 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: _____

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

☐ 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 Medicare Advantage Essential (PPO) 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: _____

Where do I return the form?
Option 1:

Complete the "Declaration of Prior Prescription Drug Coverage" form attached to this sheet and mail it back to your Medicare drug plan at:

Blue Medicare Advantage Essential (PPO)
PO Box 419169, Attn: MA Enrollment Department, Kansas City, MO 64141

Option 2:
Instead of completing the enclosed form, you can call your Medicare drug plan to provide them with additional information they need.
Blue Medicare Advantage Essential (PPO)at 888-892-8907 (TTY: 711)

What if I have questions?
If you have questions about the information in this form or the late enrollment penalty or would like to complete this form over the telephone, call your Medicare drug plan.

- Blue Medicare Advantage Essential (PPO) at 888-892-8907 seven days a week from 8 a.m. to 8 p.m. You may reach a messaging service on weekends and holidays from April 1 through September 30
- TTY: 711

You may also contact Medicare:

- Visit **www.medicare.gov** on the web
- Call 1-800-MEDICARE (1-800-633-4227)
- TTY users call 1-877-486-2048.

Y0126_21-161_C
Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The HMO products are offered by Blue-Advantage Plus of Kansas City, Inc. and the PPO products are offered by Missouri Valley Life and Health Insurance Company, both wholly-owned subsidiaries of Blue Cross and Blue Shield of Kansas City.