PACE/PACENET HEALTH & PRESCRIPTION FORM

Please return this completed form including a photocopy of any Health Insurance or Drug Coverage cards, along with your PACE/PACENET application.

Applicant Name:

Social Security Number:

Section A

Applicant Other Drug Coverage

Do you have any other Drug Coverage? ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Is this Creditable Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ MedicareRX ☐ Tricare
☐ Discount Card ☐ Veterans'
☐ PDP ☐ Access Card

Drug Coverage Information

Name of Plan: ____________________

ID#: ____________________

RXPCN#: ____________________

RXBIN#: ____________________

RXGRP#: ____________________

CMS#: ____________________

Eff Date: ____________________

Applicant Other Health Insurance

Do you have any other Health Insurance? ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ Discount Card ☐ PFFS ☐ Veterans'
☐ HMO ☐ SNP ☐ Tricare
☐ PPO ☐ Access Card

Health Coverage Information

Name of Plan: ____________________

ID#: ____________________

PCN#: ____________________

BIN#: ____________________

GRP#: ____________________

CMS#: ____________________

Eff Date: ____________________

Spouse Name:

Social Security Number:

Section B

Spouse Other Drug Coverage

Do you have any other Drug Coverage? ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Is this Creditable Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ MedicareRX ☐ Tricare
☐ Discount Card ☐ Veterans'
☐ PDP ☐ Access Card

Drug Coverage Information

Name of Plan: ____________________

ID#: ____________________

RXPCN#: ____________________

RXBIN#: ____________________

RXGRP#: ____________________

CMS#: ____________________

Eff Date: ____________________

Spouse Other Health Insurance

Do you have any other Health Insurance? ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ Discount Card ☐ PFFS ☐ Veterans'
☐ HMO ☐ SNP ☐ Tricare
☐ PPO ☐ Access Card

Health Coverage Information

Name of Plan: ____________________

ID#: ____________________

PCN#: ____________________

BIN#: ____________________

GRP#: ____________________

CMS#: ____________________

Eff Date: ____________________