PACE/PACENET Health and Prescription Coverage Form

Your Name: _____ Your Social Security Number: _____

MEDICARE

Do You Have Medicare?

Medicare Part A: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Part B: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Part D: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Claim Number (on red, white and blue card)

_____ **Medicare Claim Number**

If you answered Yes to Part A and/or Part B, what insurance company pays for your doctor office visits? _____

PRESCRIPTIONS

Do you have a Medicare Advantage Plan? (MAP, HMO, PPO) ☐ Yes ☐ No

Medicare Advantage Plan name: _____

Member #: _____

Do you have any prescription plan(s)? ☐ Yes ☐ No

If you answered Yes but your coverage is not a Medicare Part D Plan, what kind(s) of coverage do you have?

☐ **Employer/Retiree Coverage** ☐ **ACCESS Card** ☐ **Veterans'** ☐ **TRICARE**

☐ **Medigap Policy** ☐ **MAP w/Rx** ☐ **Other:** _____

If Employer/Retiree Coverage, is it Creditable Coverage? ☐ Yes ☐ No

If you answered **YES** for any prescription plan(s), please complete the information below for each plan you have. You can find this information on your insurance ID card. If you have more than one, please include all the information for your other plan(s) on the reverse side of this sheet.

Name of your Prescription Plan: _____

Member Identification Number: _____

Group Number: _____

RxBIN: _____ PCN: _____

Effective Date: _____

Contract: _____ PBP: _____

Complete this form and return it with copies of all Health and Prescription ID cards to: PACE, P.O. Box 8806, Harrisburg, PA 17105 or scan and email the documents to papace@magellanhealth.com or FAX the information to 888-656-0372.

SPOUSE'S PACE/PACENET Health and Prescription Coverage Form

Spouse Name: _____ Spouse Social Security Number: _____

MEDICARE

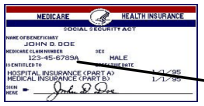
Do You Have Medicare?

Medicare Part A: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Part B: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Part D: ☐ Yes ☐ No **If Yes, Effective Date?** _____

Medicare Claim Number (on red, white and blue card)



_____ **Medicare Claim Number**

If you answered Yes to Part A and/or Part B, what insurance company pays for your doctor office visits? _____

PRESCRIPTIONS

Do you have a Medicare Advantage Plan? (MAP, HMO, PPO) ☐ Yes ☐ No

Medicare Advantage Plan name: _____

Member #: _____

Do you have any prescription plan(s)? ☐ Yes ☐ No

If you answered Yes but your coverage is not a Medicare Part D Plan, what kind(s) of coverage do you have?

☐ **Employer/Retiree Coverage** ☐ **ACCESS Card** ☐ **Veterans'** ☐ **TRICARE**

☐ **Medigap Policy** ☐ **MAP w/Rx** ☐ **Other:** _____

If Employer/Retiree Coverage, is it Creditable Coverage? ☐ Yes ☐ No

If you answered **YES** for any prescription plan(s), please complete the information below for each plan you have. You can find this information on your insurance ID card. If you have more than one, please include all the information for your other plan(s) on the reverse side of this sheet.

Name of your Prescription Plan: _____

Member Identification Number: _____

Group Number: _____

RxBIN: _____ PCN: _____

Effective Date: _____

Contract: _____ PBP: _____

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