Prescription Advantage

Re-Determination Form

Section A: General Information

This section asks questions about you. If you have a spouse who lives with you, you must supply his/her information here as well, even if he/she is not a member at this time.

1. Member Information

Mr/Mrs/Ms	Last Name	First Name	MI	Jr/Sr/etc

Social Security Number*	Medicare ID Number (HICN)**	Railroad Retirement Number

Date of Birth	Gender ❑ Male ❑ Female	Telephone Number	Preferred Written Language

2. Member Address

Primary Address	City	State	Zip Code
Mailing Address (if different from primary)	City	State	Zip Code

3. Do you have a spouse who lives with you? ❑ Yes ❑ No

If yes, you must complete part 4 below even if your spouse is not a member at this time.

4. Spouse Information

Mr/Mrs/Ms	Last Name	First Name	MI	Jr/Sr/etc

Social Security Number*	Medicare ID Number (HICN)**	Railroad Retirement Number

Date of Birth	Gender ❑ Male ❑ Female	Telephone Number	Preferred Written Language

*The decision to provide your Social Security number is voluntary. Prescription Advantage will use this number to obtain information regarding other state and federally funded programs.

****If you are enrolled in Medicare, you must provide your Medicare ID number (HICN) and a copy of your Medicare card.**

Section B: Household Information

This section asks questions about any relatives, other than you or your spouse, that live in your household and depend on you fro at least one-half of their financial support.

1. **How many relatives (besides your spouse) live with you and depend on you or your spouse to provide at least one-half of their financial support?**

   Relatives may include anyone related to you by blood, marriage, or adoption.

   ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9

Section C: Extra Help from Medicare

If you are a Medicare beneficiary with limited income and resources, you may qualify for the low income subsidy from Medicare, known as 'Extra Help'. Extra Help will lower your deductible and co-payments and help pay your monthly Medicare prescription drug plan premium. Prescription Advantage requires all members who may qualify for Extra Help to apply for this benefit. After reviewing your Re-Determination Form, we will let you know if you might be eligible for Extra Help and we will assist you with this process.

To help us determine if you may qualify for Extra Help, please answer the following question. Your answer will not affect your eligibility for Prescription Advantage.

Are your savings, investments, and real estate (other than your home) worth more than the resource limits for Extra Help? Include assets you own by yourself, with your spouse or with someone else. *Do not include* your home, life insurance policies, burial plots or personal possessions.

Refer to the cover letter included with this form for the current single and married resource limits.

❑ Yes ❑ No ❑ Not Sure

Section D: Other Prescription Drug Coverage

Please indicate below which (if any) other health coverage you and/or your spouse have that covers outpatient prescription drugs.

	You	Your Spouse
1. Are you enrolled in a Medicare prescription drug plan or a plan that offers creditable coverage?	❑ Yes ❑ No ❑ Not sure *If yes, please provide the name of your plan below.*	❑ Yes ❑ No ❑ Not sure *If yes, please provide the name of your plan below.*
2. Do you have any other health insurance?	❑ Yes ❑ No ❑ Not sure *If yes, please provide the name of your plan below.*	❑ Yes ❑ No ❑ Not sure *If yes, please provide the name of your plan below.*
3. If you have other health insurance, does it include prescription drug coverage?	❑ Yes ❑ No ❑ Not sure	❑ Yes ❑ No ❑ Not sure
4. Do you receive health coverage through Medicaid (MassHealth or CommonHealth)?	❑ Yes ❑ No ❑ Not sure	❑ Yes ❑ No ❑ Not sure

Make sure you include the following documents:

1. A copy of the front and back of your insurance card for any coverage you have;
2. If you are enrolled in a creditable coverage plan, provide a copy of a letter from the plan's administrator to verify your coverage. Creditable coverage is insurance coverage for prescription drugs but is not a Medicare prescription drug plan.

Section D: Member and Spouse Information

All members must answer question 1 below. **If you are under 65 years of age**, you must also answer question 2 regarding your disability status.

	You	Your Spouse
1. Are you currently working?	❑ **Yes** ❑ **No** If yes, how many hours **per month** do you work?	❑ **Yes** ❑ **No** If yes, how many hours **per month** do you work?
2. Do you have a qualified disability?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Section E: Income Documentation

Gross monthly income is the total amount of money you receive from any source for you and your spouse, if you live together. You must submit documents to verify each type of income you receive. These documents will be used by Prescription Advantage to determine your membership category.

Important Notes About Income Calculation

- Income is calculated using the total income as reported on federal income tax returns and current Social Security income as reported on form(s) SSA-1099. For members not required to file a federal income tax return, income is calculated using alternative documents. See page 5.
- Income is calculated using your **gross** annual household income. This is the amount **prior** to any deductions you may have for healthcare costs or other purposes.
- Income counted includes the total amount of money earned or unearned from any source, including but not limited to wages, salaries, rents, pensions, dividends, and interest.
- Do not send original documents, send copies. **Originals will not be returned.**
- **ALL** members who receive Social Security benefits must submit Social Security Income documents such as an annual benefit statement (SSA-1099 form) or Social Security Benefit Award letter.

Have you or your spouse filed federal income tax returns within the past 2 years? ❑ **Yes** ❑ **No**

<table>
<tr><th colspan="3">Income Documentation</th></tr>
<tr><th colspan="3">NOTE: ALL members must submit Social Security income documents.</th></tr>
<tr><th>If you FILE federal income taxes...</th><th colspan="2">If you DO NOT FILE federal income taxes...</th></tr>
<tr><td rowspan="2">Send copies of your Social Security annual benefit statement (SSA-1099 form) or benefit award letter and your most recently filed federal income tax return. State tax returns are not acceptable.

• 1040, 1040A, 1040EZ
• Telefile Tax Record including confirmation number</td><td colspan="2">Send copies of your Social Security annual benefit statement (SSA-1099 form) or benefit award letter and your most recent 1099 or W2 form(s) for each type of income listed below that you receive. If you do not receive 1099 or W2 form(s), contact customer service for other documents you may submit. All documents must be for the PREVIOUS calendar year. (Example: in 2011, documents must be for 2010)</td></tr>
<tr><td>Pension Income
Dividends/Interest
Employment Income
Retirement Accounts:
• IRA • 401K
• 403B • Railroad</td><td>Rental Income
Capital Gains Income
Alimony
Unemployment</td></tr>
</table>

Any of the following types of income listed on your federal tax return that you no longer receive will not be used to calculate income. You must verify that you do not receive the income or cannot receive it again. This applies to wages, IRAs, pensions/annuities, and alimony. Documents required for removal of income are listed below.

Income Type	Documents Required for Removal of Income
Wages (send **both** items)	1. Letter from former employer on company letterhead indicating last day worked; **and** 2. W-2(s) showing total amount earned from that employer to verify total on tax return.
IRA (send items 1 **and** 2) **or** (send item 3)	1. Document from company that administered IRA indicating account is closed; **and** 2. 1099 forms for all IRA accounts in applicant/member's name **or** 3. 1099 form indicating a 'total distribution'.
Pension/Annuity (send **both** items)	1. Document from company that administered pension/annuity stating account is closed; **and** 2. 1099 forms for all pensions/annuities received by applicant/member.
Alimony (send item 1 **or** 2)	1. Copy of divorce decree outlining details of alimony including end/ended date; **or** 2. Letter from provider of alimony payments indicating the date the payments ended.

You must provide documentation regarding your income.

Section G: Signatures

Please read the following statements and sign and date the bottom of this page. Because we require verification of household income, your spouse must also sign if he/she lives with you, even if he/she is not a member at this time.

I agree to abide by all Prescription Advantage regulations and will notify Prescription Advantage, in writing, within fifteen (15) business days of any change to my personal information which may affect my eligibility or level of benefits. This information includes, but is not limited to, changes in residence, marital status, income, and Medicare status.

I understand that Prescription Advantage may share my personal information with other state and federal agencies, as well as with any other agency providing me prescription drug coverage.

I hereby certify, under the pains and penalties of perjury, that I have examined all the information on this form and the accompanying documentation and that it is true, complete, and correct to the best of my knowledge and belief. I further certify that any information I submit in the future related to this form and the accompanying documentation will also be true, complete, and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted and any accompanying or supplemental information is true, complete, and correct to the best of your knowledge and belief.

X ______________________________ Date: ______________

Signature of member (or designee if member is unable to complete this form)

X ______________________________ Date: ______________

Signature of member's spouse (or designee if member's spouse is unable to complete this form)

Temporary Authorization

If someone helped you complete this Re-Determination Form, such as a family member or advocate, and you would prefer that we contact that person if we have questions or need more information, please provide his / her contact information in the space below.

By providing this information, you authorize Prescription Advantage to discuss this form, its contents, and required documentation with your designee. This authorization is for the purpose of completing the Prescription Advantage Re-Determination process only and will end once a final membership eligibility decision is made.

If you wish to designate someone to act on your behalf on a permanent basis, please refer to the Supplement A Form included in this booklet.

Name of Applicant / Member	Name of Spouse	Telephone Number	
Name of Temporary Designee (Please print)		Telephone Number	
Address of Temporary Designee	City	State	Zip Code

X ______________________________ **Date:** ______________
Signature of Member (or designee if member is unable to complete this form)

X ______________________________ **Date:** ______________
Signature of Spouse (or designee if spouse is unable to complete this form)

X ______________________________ **Date:** ______________
Signature of Temporary Designee

Authorized Representative

This form allows you to designate someone to make decisions for you regarding Prescription Advantage as well as have access to your Protected Health Information. Protected Health Information includes all enrollment, eligibility, billing, and prescription drug claims information.

If you want to grant someone the authority to act on your behalf or if you wish to continue with an existing Authorized Representative, please read the detailed information below, fill out the necessary information on the reverse side, and sign where indicated. If you and your spouse are both members and want someone to act on your behalf, you both must agree to have an Authorized Representative designated for your household. You must agree to designate the same Authorized Representative, and you both must sign this form.

An Authorized Representative has the authority to make decisions for you (and your spouse) about your Plan membership(s) and participation. For example, an Authorized Representative may submit a request to terminate your membership in Prescription Advantage on your behalf.

Prescription Advantage will send your approval letter(s), identification card(s), member notices, bills, and all other Plan correspondence to your Authorized Representative instead of to you.

By completing this form, you authorize Prescription Advantage to share all verbal and written communication and personal data with your designated Authorized Representative.

You are not required to designate an Authorized Representative. If you do not wish to have an Authorized Representative, do not complete this supplement.

If you would like to designate an Authorized Representative, please complete and sign the reverse side of this form and return it with your Re-Determination form. The person you are designating as your Authorized Representative must also sign the form.

If you have any questions about Authorized Representatives or how to complete this form, please call Prescription Advantage Customer Service at 1-800-AGE-INFO (1-800-243-4636) and press 2, or TTY (toll free) for the deaf and hard of hearing at 1-877-610-0241.

Authorization

I (We) designate the following person to be my (our) Authorized Representative and authorize Prescription Advantage to release my (our) Protected Health Information to him/her. By signing this form to designate an Authorized Representative, I am indicating that:

- I understand this authorization covers my Protected Health Information, including all enrollment, eligibility, billing, and prescription drug claims information.
- I understand that all Prescription Advantage correspondence will go to my Authorized Representative instead of to me. This includes approval letter(s), identification card(s), member notices, bills, and all other Prescription Advantage correspondence.
- I understand that this designation will continue as long as I am a member of Prescription Advantage unless I cancel or change this permission. I may do so at any time by sending a letter to: **Prescription Advantage, PO Box 15153, Worcester, MA 01615-0153**
- I understand that even if I cancel or change this permission, Prescription Advantage cannot take back information that has already been released.
- I understand that after Prescription Advantage releases my information to my Authorized Representative, it may no longer be protected by privacy law, and may be given out again by the person to whom the information was released.
- I understand that my actions to designate, change, or remove an Authorized Representative will not impact my ability to receive benefits from Prescription Advantage.

If the designated Authorized Representative is person with legal authority to make decisions on your behalf, such as a legal guardian or a person with power of attorney, please include documentation to verify this status.

Name of Applicant / Member	Name of Spouse	Telephone Number	
Name of Authorized Representative (Please print)		Telephone Number	
Address of Authorized Representative	City	State	Zip Code

X ______________________________ **Date:** ____________
Signature of Member (or Authorized Representative if member is unable to complete this form)

X ______________________________ **Date:** ____________
Signature of Spouse (or Authorized Representative if spouse is unable to complete this form)

X ______________________________ **Date:** ____________
Signature of Authorized Representative

This form CANNOT be processed unless signed by all persons listed above.

P.O. Box 15153 ♦ Worcester, MA 01615-0153
1-800-AGE-INFO (1-800-243-4636) and press 2 ♦ www.800ageinfo.com
TTY 1-877-610-0241 (toll free) for the deaf and hard of hearing

English	Important! Please have this notice translated immediately.
Armenian	Կարևոր է.– Խնդրվում է այս ծանուցումը անմիջապես թարգմանեք
Chinese	务请注意！请立即翻译本通知。
Cambodian	សំខាន់ណាស់! សូមរកអ្នកណាម្នាក់ ឲ្យបកប្រែខិតប័ណ្ណនេះ ជាមួយរំពេច
French	Important ! Faites traduire cette notice immédiatement.
Greek	Προσοχη! Παρακαλω μεταφραστε αυτο το μυνημα αμεσως.
Haitian	Enpòtan! Tanpri fè tradwi anons sa a imedyatman.
Italian	Importante! Far tradurre immediatamente questo avviso.
Laotian	"ສຳຄັນທີ່ສຸດ! ກະລຸນາແປຄຳເຕືອນອັນນີ້ທັນທີທັນໃດ"
Polish	Ważne! Proszę przetłumaczyć tę uwagę natychmiast.
Portuguese	Importante! Favor mandar traduzir este folheto imediatamente.
Russian	Крайне важно! Пожалуйста, переведите это объявление немедленно.
Spanish	¡Importante! Por favor traduzca este folleto inmediatamente.
Vietnamese	Quan trọng! Xin vui lòng cho dịch tờ thông báo này ngay.