



DATE: _____ ID #: _____

FIRST NAME: _____ LAST NAME: _____

Dear Member:

The Centers for Medicare & Medicaid Services, the federal agency that administers Medicare, requires us to verify and update our records periodically. Please answer the following questions about your prescription drug coverage. The information you provide will remain **confidential** and will not affect your Medicare coverage or your membership with MVP Health Care.

If both you and your spouse receive a copy of this questionnaire, please complete and return both questionnaires.

Do you have any prescription drug coverage **other than** MVP's Medicare Part D that is effective on or after your enrollment with MVP?

- No other pharmacy coverage. [Stop and return this to the address in the grey box below.]
- Yes, I have other pharmacy coverage. [Please continue to the next section.]

Please check **any** of the following boxes that apply and use your pharmacy insurance card (see sample below), **not** your MVP Medicare Part D member ID card, to fill in the following information.



New York State EPIC

Member ID: _____ Rx Group: NYEPIC Rx BIN: 012345

Other State Assistance Program

State of Residence : _____ Member ID: _____
Rx Group: _____ Rx BIN: _____

VA (Veterans Affairs) Pharmacy Benefit

Other (Example: Employer Group Coverage)

Plan Name: _____

Member ID: _____

Rx Group: _____

Rx BIN: _____

If coverage is through an Employer Group, are you still working?

Yes

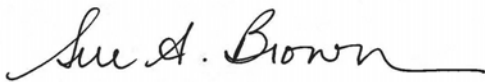
No

If you checked "Yes", please list the name of the Employer Group: _____

Please return your completed questionnaire to the address shown in the grey box below. If you are not able to complete this questionnaire by yourself, please have a family member or caregiver help you. If you are able to send a photocopy of the pharmacy insurance card you used to fill this form out, please include it with the questionnaire.

If you have any questions, please call the MVP Medicare Customer Care Center at **1-800-665-7924**. **TTY users should call 1-800-662-1220. Representatives are available to serve you:** Monday – Friday from 8 am – 8 pm and Saturday from 8 am – 4 pm. **From October 1st – February 14th,** representatives are available every day, from 8 am – 8 pm. If you are a USA Care member, please call **1-888-597-4419**.

Sincerely,



Vice President, Service Operation

Statement of Confidentiality

MVP Health Care respects your right to privacy. Your responses to this questionnaire will not be shared with anyone without your prior consent. All the information that would let someone identify you or your family will be kept private. The information you provide will remain confidential and will not affect your Medicare coverage or your membership with MVP Health Care.

Please return the questionnaire to:

Coordination of Benefits Department | MVP Health Care | PO Box 2207 | Schenectady, NY 12301