



*Prescription
Advantage*

Your Plan for Affordable Prescriptions

APPLICATION FORM & PROGRAM OVERVIEW

Revised January 2010



For Massachusetts residents:

- **65 years of age or older**
- **Disabled, under age 65**

Administered by the Commonwealth of Massachusetts
Executive Office of Elder Affairs



Prescription Advantage

Thank you for your interest in Prescription Advantage, the state-sponsored prescription drug program administered by the Commonwealth of Massachusetts Executive Office of Elder Affairs. This booklet contains an overview of Prescription Advantage and an Application Form. Carefully read and understand all sections before you complete and submit the Application Form.

Eligibility Requirements

Prescription Advantage is available to Massachusetts residents who are not MassHealth or CommonHealth members and who are:

1. Age 65 or older; or
2. Under age 65, work no more than 40 hours per month, earn no more than the maximum income to qualify for category 2 or S2 (see the enclosed Rate Schedule Guide for detailed income qualifications), and meet disability guidelines (see page 6 of the application for details about the documentation needed to demonstrate disability).

Important Notes:

- Individuals eligible for Medicare must also be enrolled in a Medicare prescription drug plan or a plan offering creditable coverage* and must not have a gross annual household income exceeding 500% of the Federal Poverty Level (see the enclosed Rate Schedule Guide for detailed income qualifications).
- Individuals receiving assistance from MassHealth to pay for Medicare Part A and/or Part B premiums, deductibles and co-payments may still be eligible for Prescription Advantage.
- If there are more than two people in your household, please call Prescription Advantage for more information regarding income eligibility requirements.

*Creditable coverage is coverage as good or better than drug coverage offered by Medicare and is usually provided by an employer or union.

Prescription Advantage does not charge its members a monthly premium to receive benefits. Applicants approved for Prescription Advantage in the S5 membership category are required to pay an annual enrollment fee. For specific information regarding benefits provided by Prescription Advantage, please see the Rate Schedule Guide included with this application.

Important Message

Applicants eligible for Medicare may **apply** for Prescription Advantage whether or not they are enrolled in a Medicare prescription drug plan. However, applicants must be enrolled in a Medicare prescription drug plan or a plan offering creditable coverage before they can begin receiving benefits from Prescription Advantage.

Prescription Advantage

Benefits for Massachusetts Residents Eligible for Medicare

Prescription Advantage will provide you with coverage to help pay for prescription drugs covered by your Medicare Part D or creditable coverage plan. Refer to the enclosed Rate Schedule Guide for specific benefit information based on membership category. If you are **NOT ELIGIBLE** for Medicare, see the information on the next page.

Co-payments (for all Medicare-eligible members):

Co-payment assistance is based on membership category. Once co-payment assistance begins, your total co-payments will not be more than the amounts listed on the Rate Schedule Guide. Prescription Advantage does not provide assistance for drugs not covered by your drug plan, except for benzodiazepine drugs (commonly used for anxiety and sleep aid). For Category S5 members, Prescription Advantage will not pay for any drugs covered by your drug plan or benzodiazepine drugs until your costs reach the S5 out-of-pocket spending limit. See the Rate Schedule Guide for more specific co-payment information.

Note: Applicants approved as Category S2, S3, or S4 members are asked to supply a copy of their most recent Explanation of Benefits from their Medicare Part D or other prescription drug plan. You have the option of sending the Explanation of Benefits with this application. If you send it with this application, Prescription Advantage can verify your drug purchases while your application is being processed and apply the costs toward your drug spending if/when you are approved for benefits. If you do not choose to include it now and you are approved for the Plan, you will have 90 days from your benefit effective date to provide the information. More details will be included with your approval notification.

Annual Out-of-Pocket Spending Limit (for all Medicare-eligible members):

If your total spending for **co-payments** reaches your spending limit amount, Prescription Advantage will cover the full cost of your co-payments for the remainder of the **calendar** year for all drugs covered by your drug plan and benzodiazepine drugs. **Note:** Out-of-pocket spending costs begin to accumulate once you become a Prescription Advantage member. Any costs incurred prior to your effective date of coverage cannot be applied towards your out-of-pocket spending limit. The Rate Schedule Guide lists the out-of-pocket limits for each membership category.

Extra Help from Medicare:

Medicare provides eligible beneficiaries with Extra Help to pay for prescription drugs. Prescription Advantage requires applicants who may qualify for Extra Help to submit an application to Social Security. If you have already applied for Extra Help, include a copy of the determination letter you received from Social Security with this application. See the Rate Schedule Guide for more details.

Prescription Advantage

Benefits for Massachusetts Residents Not Eligible for Medicare

If you are not eligible for Medicare, Prescription Advantage may be able to offer you primary prescription drug coverage. See the Rate Schedule Guide for specific benefit information.

Deductibles and Co-payments:

A deductible is the amount of money you must pay toward your prescription drug costs each quarter and is determined by membership category. If your category has a deductible, you will be charged accordingly at the beginning of each quarter when you present your Prescription Advantage card at the pharmacy. Once you pay your quarterly deductible (if any), you will pay only the co-payment amount listed on the Rate Schedule Guide for the remainder of that quarter.

Annual Out-of-Pocket Spending Limit:

If your total spending for deductibles and co-payments reaches your out-of-pocket spending limit, Prescription Advantage will cover the full cost of your co-payments for the remainder of the calendar year for all drugs covered by Prescription Advantage.

How to Determine Which Drugs are Covered:

Prescription Advantage utilizes a Plan formulary, which is a list of prescription drugs available to members. The Plan formulary is developed, reviewed and updated by a select panel of pharmacists. To find out if your medications are covered, 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.

Prescription Advantage

Completing this Application Form

- ◆ Carefully read and answer all questions on the Application Form. Please **print** except where a signature is indicated.
- ◆ The Rate Schedule Guide provides important information regarding Prescription Advantage benefits not included in this booklet. Review the Guide and keep it nearby for reference as you complete the application.
- ◆ Collect and make **copies** of all the documents, such as federal tax returns and/or 1099 forms, you must provide to Prescription Advantage. Original documents cannot be returned to you.
- ◆ Complete and sign the Authorized Representative Form if you wish to grant someone other than yourself access to your Protected Health Information. Submit the form with your application.
- ◆ Sign the completed Application Form and send it with the copies of your documentation to:

**Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153**

You may also fax your application to Prescription Advantage at 508-793-1133.

Important Notes:

- ◆ **Your application is not complete until we receive all required documentation. If information is missing, you will receive a letter on yellow paper outlining what is needed. Once all documentation is received, your eligibility for Prescription Advantage will be evaluated and if you are eligible, you will be approved for the program.**
- ◆ Once this application has been submitted, it is your responsibility to keep Prescription Advantage updated if your information changes. Failure to provide updated information may result in the denial of your application or the termination of your membership.
- ◆ This application may be used for you alone, or for you and your spouse, if you live together and both wish to apply. Any other member(s) of your household applying for Prescription Advantage, must complete a separate application.



This symbol indicates that in addition to answering the questions on the application, you must submit documentation to support the information you provided.

If you have any questions about Prescription Advantage or need assistance completing this Application 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.

A. Applicant and Spouse Information

This section asks questions about you and your spouse. If your spouse lives with you, you must complete both sections below even if he / she is not applying at this time. If you live together and are both applying, you may use one application form. Any additional household members applying for Prescription Advantage must complete a separate form.

Who is applying on this application? <input type="checkbox"/> You <input type="checkbox"/> You and your spouse

APPLICANT

Mr/Mrs/Ms	Last Name	First Name	MI	Jr/Sr/etc
Social Security Number*	Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your Medicare ID Number**		Railroad Retirement Number	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Written Language		
Do you have a spouse who lives with you? If yes, complete the <i>Spouse</i> section below. <input type="checkbox"/> Yes <input type="checkbox"/> No				

SPOUSE (complete this section if your spouse lives with you)

Mr/Mrs/Ms	Last Name	First Name	MI	Jr/Sr/etc
Social Security Number*	Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list your Medicare ID Number**		Railroad Retirement Number	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Written Language		
Are you a Prescription Advantage member? If yes, list your Prescription Advantage ID number. <input type="checkbox"/> Yes <input type="checkbox"/> No Prescription Advantage ID number:				

* 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 have Medicare Part A or B, please include a copy of the front of your Medicare ID card with your application.**

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 for at least one-half of their financial support. The number of people living in your household may affect the benefits you receive. Income guidelines for households with three or more people are different from the single / married amounts listed on the Rate Schedule Guide. Call Prescription Advantage for more information.

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. **Do not** include yourself or your spouse in this number.

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
| None | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

2. If any other members of your household, other than your spouse, are enrolled in Prescription Advantage or applying for benefits on a separate application, please provide his / her information below. Use an additional sheet of paper if you are including information for more than two household members.

Household Member 1

Last Name		First Name		MI
Prescription Advantage ID Number	Medicare ID Number		Relationship to Applicant	

Household Member 2

Last Name		First Name		MI
Prescription Advantage ID Number	Medicare ID Number		Relationship to Applicant	

C. Residence and Contact Information

Please provide your primary residence and contact information. Prescription Advantage is only available to those with a primary residence located in Massachusetts. A primary residence is one in which you reside for at least six (6) months during the calendar year. A seasonal or temporary residence in Massachusetts does not qualify as a primary residence.

Note: Prescription Advantage understands that people may sometimes reside at another location. If you have a temporary address (e.g., you leave the state for the winter), you must notify customer service before you leave for that location so we can update your mailing address in case we need to contact you regarding your Prescription Advantage benefits. You must also notify customer service when you return to your primary address.

Important Information:

- ◆ Cellular phones are not considered to be a secure means of transmitting personal information. For your protection, please do not provide a cellular phone number. If our only means of contacting you is via a cellular phone, please be aware that any personal information discussed may not be secure.
- ◆ You may not give a post office box as a primary residential address.

1. Primary Residential Address (no P.O. Boxes)

Street Number and Name

Unit Number / Apt. Number (if applicable)

City

State

Zip Code

(____)

Telephone Number

2. Mailing Address (if different than your primary residential address)

Street Number and Name or P.O. Box

Unit Number / Apt. Number (if applicable)

City

State

Zip Code

(____)

Telephone Number (if different than above)

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.

- ◆ It is your responsibility to compare your current prescription drug coverage with the coverage provided by Prescription Advantage and determine whether you need Prescription Advantage to supplement that coverage.
- ◆ If eligible for Medicare, you must join a Medicare prescription drug plan or have creditable coverage (coverage as good as the drug coverage offered by Medicare) to receive Prescription Advantage benefits.

	APPLICANT	SPOUSE
1. Are you enrolled in a Medicare prescription drug plan or a plan that offers creditable coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <i>If yes, please provide the name of your plan below.</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <i>If yes, please provide the name of your plan below.</i> _____
2. Do you have any other health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <i>If yes, please provide the name of the plan below.</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <i>If yes, please provide the name of the plan below.</i> _____
3. If you have other health insurance, does it include prescription drug coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
4. Do you receive health coverage through Medicaid (MassHealth or CommonHealth)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

Make sure you include the following documents with your application:



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.

E. 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 applicants who may qualify for Extra Help to apply for this benefit. After reviewing your application, 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 Prescription Advantage Rate Schedule Guide for the current single and married resource limits.

Yes No Not Sure

	APPLICANT	SPOUSE
<p>Have you applied to Social Security for Extra Help with your Medicare prescription drug costs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p><i>If yes, were you approved for the extra help?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p> <p><i>If yes, were you approved for the extra help?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</p>



If you already applied for Extra Help, please send a copy of the determination letter you received from Social Security. If you have not received a determination letter, please send a copy of your Extra Help application receipt letter from Social Security.

F. Applicant and Spouse Information

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

	APPLICANT	SPOUSE
1. Are you currently working? If yes, how many hours <input type="text"/> per month do you work?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours <input type="text"/> per month do you work?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours <input type="text"/> per month do you work?

	APPLICANT	SPOUSE
2. Do you have a qualified disability? NOTE: If you are under age 65 and do not have a qualified disability, you are not eligible for Prescription Advantage benefits. 	<input type="checkbox"/> Yes <input type="checkbox"/> No Please send a copy of one of the following documents. Check the box next to the document you are submitting. <input type="checkbox"/> A copy of a current Social Security Administration award letter for SSDI or SSI benefits; <input type="checkbox"/> A copy of your Medicare card; <input type="checkbox"/> A copy of a certificate of blindness from the Massachusetts Commission for the Blind; <input type="checkbox"/> A copy of the determination of disability from MassHealth or CommonHealth (Medicaid); <input type="checkbox"/> Written verification of SSDI or SSI benefits signed by an authorized Social Security Claims Representative on Social Security letterhead.	<input type="checkbox"/> Yes <input type="checkbox"/> No Please send a copy of one of the following documents. Check the box next to the document you are submitting. <input type="checkbox"/> A copy of a current Social Security Administration award letter for SSDI or SSI benefits; <input type="checkbox"/> A copy of your Medicare card; <input type="checkbox"/> A copy of a certificate of blindness from the Massachusetts Commission for the Blind; <input type="checkbox"/> A copy of the determination of disability from MassHealth or CommonHealth (Medicaid); <input type="checkbox"/> Written verification of SSDI or SSI benefits signed by an authorized Social Security Claims Representative on Social Security letterhead.



Do not forget to provide documentation with your application if you answered YES to question 2 above and you are under age 65.

G. Income

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. Common types of income include Social Security, employment, pensions, dividends / interest, disbursements from retirement accounts, capital gains, unemployment, rental, and alimony. 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 the applicant and his/her spouse. For applicants not required to file a federal income tax return, income is calculated using alternative documents. See page 8.
- ◆ 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.
- ◆ You must verify any income you receive. A list of acceptable income documents is provided on page 8. If you receive income that is not listed, please call customer service for acceptable documentation.
- ◆ Do not send original documents, send copies. **Originals will not be returned.**
- ◆ **ALL** applicants 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.



You must provide documentation regarding your income.
For a list of acceptable documentation, please see page 8.

H. Income Documentation

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

Income Documentation		
NOTE: ALL applicants must submit Social Security income documents.		
If you FILE federal income taxes...	If you DO NOT FILE federal income taxes...	
<p>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.</p> <ul style="list-style-type: none"> • 1040, 1040A, 1040EZ • Telefile Tax Record including confirmation number 	<p>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 2010, documents must be for 2009)</p>	
	Pension Income Dividends/Interest Employment Income Retirement Accounts: • IRA • 401K • 403B • Railroad	Rental Income Capital Gains Income Alimony Unemployment

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.

Please read the following statements and sign and date the bottom of this page. Because we require information regarding your household income, your spouse must also sign if he/she lives with you, even if he/she is not applying 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 applicant (or designee if the applicant is unable to complete this form)

X _____ **Date:** _____
Signature of applicant's spouse (or designee if the applicant is unable to complete this form)

Temporary Authorization

If someone helped you complete this application, 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 application, its contents, and required documentation with your designee. This authorization is for the purpose of completing the Prescription Advantage application 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 Applicant (or designee if applicant is unable to complete this form)	
X _____	Date: _____
Signature of Spouse (or designee if applicant is unable to complete this form)	
X _____	Date: _____
Signature of Temporary Designee	

Supplement A Form

Authorized Representative

This form allows you to designate someone to make decisions for your household 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, please read the detailed information below, fill out the necessary information, and sign where indicated. If you and your spouse are both applying and you want someone to act on your behalf, you both must agree to have an Authorized Representative designated for your household. You both 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 application.

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.

Supplement A Form

Authorization

I (We) designate the person listed below 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 indicate that:

- I understand this authorization covers my Protected Health Information, including all enrollment, eligibility, billing, and prescription drug claims information.
- I understand that all Plan 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 Plan 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 a person with legal authority to make decisions on your behalf, such as a legal guardian or 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 Applicant (or Authorized Representative if applicant is unable to complete this form)	
X _____	Date: _____
Signature of Spouse (or Authorized Representative if applicant is unable to complete this form)	
X _____	Date: _____
Signature of Authorized Representative	

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

Check off each box as you read the statement below to ensure this application is complete and ready for processing. Applications cannot be processed until we have all required documentation. Missing information will delay your application.

Did you remember to:

- Include the following documentation?
 - ⇒ Proof of income for all members of your household;
 - ⇒ Proof of disability if you are under age 65;
 - ⇒ A copy of your identification card for any other prescription drug coverage you receive, including Medicare Part D (see page 4);
 - ⇒ A copy of a letter from the administrator of your prescription drug coverage indicating that you have creditable coverage (see page 4). Creditable coverage is insurance coverage for prescription drugs but is not a Medicare prescription drug plan;
 - ⇒ A copy of any letter you received from Social Security regarding your application for Extra Help (see page 5);
 - ⇒ A copy of the front of your Medicare card (if you have Medicare);
- Sign and date the Application Form?
- Provide information regarding your spouse, including his/her signature, if he/she is living with you, even if your spouse is not applying at this time?
- Make a copy of the Application Form and all enclosed documentation for your records?
- Complete, sign, and include the Authorized Representative Form (Supplement A) if you wish to designate an Authorized Representative? **This form cannot be processed unless signed.**
- Determine and apply the appropriate postage? **Insufficient postage will delay or prevent the receipt of your application.**
- Send **copies** of all of your documentation? (Originals will not be returned.)

Please send the completed Application Form with required documentation to:

**Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153**

or fax to 508-793-1133

If you have any questions about Prescription Advantage or need help completing this form, please call 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.

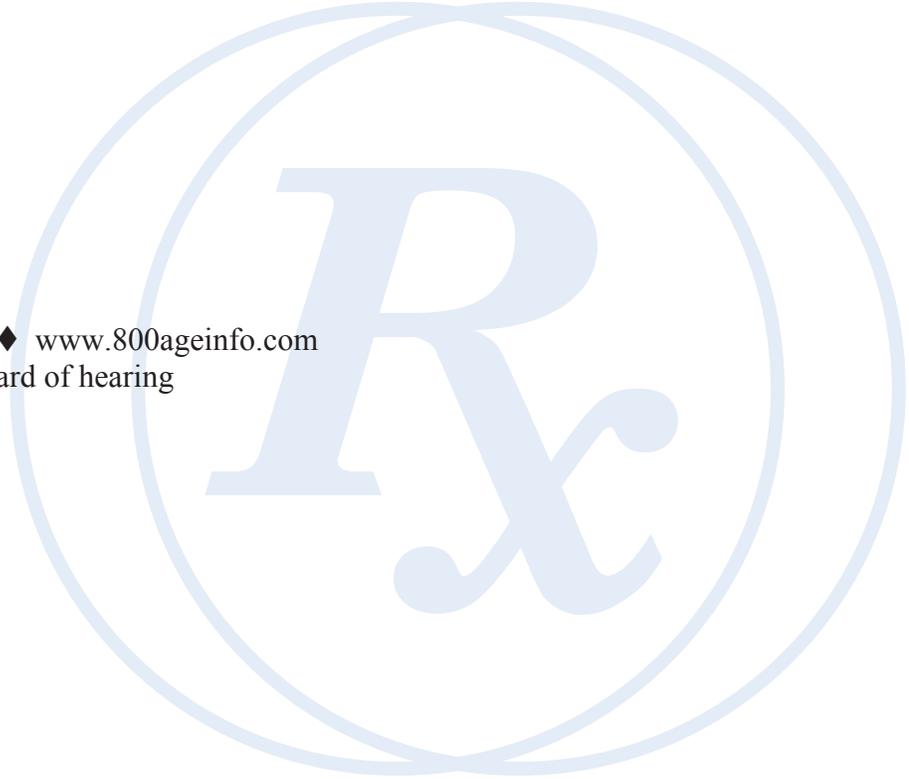
Administered by the Commonwealth of Massachusetts Executive Office of Elder Affairs





**Prescription
Advantage**

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 Վարկեր է. – Խնդրվում է այս ծանուցումը անմիջապես թարգմանել
- 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.