aetna®

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: January 31, 2022

Enrollee Name: Claude Simon

Address: 71 Tonjes Rd
Callicoon NY 12723

Phone: 9124410062

Medicare Health Insurance Claim #:
(from red, white, and blue Medicare card)
5CE9TJ9AE45

Name of Medicare Prescription Drug Plan:
Silverscript

0030039403560

Please check all boxes that apply to you.	Dates of Coverage (month/year)
☐ I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP). Name: _____	From: _____ To: _____
☐ I had creditable* prescription drug coverage from a Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state. Name of SPAP: _____ If you are in an SPAP, what state do you live in: _____	From: _____ To: _____
☐ I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits).	From: _____ To: _____
☐ I had prescription drug coverage through my TRICARE or other military coverage.	From: _____ To: _____
☐ I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage.	From: _____ To: _____
☐ I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: _____ To: _____
☐ I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: _____ To: _____
☑ I had creditable* prescription drug coverage from a different source not listed above. Name of other source: Silverscript	From: 7-21 To: 12-21

*"Creditable" means that your prior coverage met Medicare's minimum standards.

see note

☐ I have/had Extra Help from Medicare to pay for my prescription drug coverage.	From: _____ To: _____
☐ I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: _____	From: _____ To: _____
☐ I never had creditable* drug coverage.	

Please complete this section: "To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by SilverScript® Insurance Company or by Medicare."

Signature: Chad Sims

Date: *(month/day/year)*: 1-31-2022

If you are the representative, you must provide the following information:

Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

*Note
Silverscript improperly terminated my coverage for non-payment. They never sent a bill!
See attached reference to a billing issue at Silverscript!

aetna®
P.O. Box 30005, Pittsburgh, PA 15222-0330

T19 P1 1743 (270) 093354353628

CLAUDE A SIMON
71 TONJES RD
CALLICOON, NY 12723-5729

January 13, 2022
Payment ID: GA2712679
Reference ID: INVMPREM

0010033536280

Dear CLAUDE A SIMON:

Thank you for your membership in SilverScript SmartRx PDP, one of the Prescription Drug Plans offered by SilverScript® Insurance Company, a Medicare-approved Part D sponsor. Providing you with quality service is important to us and we appreciate the opportunity to provide your Medicare prescription drug coverage.

SilverScript (PDP) previously encountered a delay in processing your monthly invoice. Enclosed is an invoice that brings your billing up to date. We apologize for any inconvenience this may cause. **If you are unable to pay your premium balance in full by the due date listed on your invoice and would like to set up a payment plan, please contact us prior to your due date at the phone number listed below.**

For questions regarding the amount due or to set up a payment plan, please call Customer Care toll free at 1-855-651-4856, 24 hours a day, 7 days a week. TTY users should call 711. A plan representative will be happy to assist you.

Sincerely,

SilverScript Insurance Company

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

You must continue to pay your Medicare Part B premium.