ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

MULTIPLE PHARMACY COVERAGE INQUIRY FORM

In order to pay your prescription drug claims quickly and accurately under Uniform Medical Plan's prescription coverage, we request information regarding other **prescription drug** coverage you and your dependents may have. You will receive a separate form from UMP, administered by Regence BlueShield, requesting information about other medical coverage. Please complete this form immediately and return it to ArrayRx by mail or fax. You can also call us with the information at 1-888-361-1611 (TRS: 711).

ArrayRx
P.O. Box 40168
Portland, Oregon 97240-0168
Phone: 888-361-1611 (TRS: 711)
Fax: 800-207-8235

Do you or any family member covered by Uniform Medical Plan have any other prescription coverage or has any such coverage existed during the last six months? ☐**Yes** (If yes, please complete the section below.) ☐**No**

1. UMP Information		
Subscriber name:	UMP ID#:	Subscriber Date of Birth:
Email:	Phone:	

2. Other Insurance Information		
Name of policyholder:	Policyholder ID #:	Policyholder date of birth:
Name of insurance company:	Insurance company address (street or PO Box, city, state & zip):	
Insurance company telephone #:	Date this coverage began:	Date this coverage ended:

Type of coverage:
☐Retiree ☐COBRA ☐Group ☐Individual ☐Medicare Part A ☐Medicare Part B ☐Medicare Part D
☐Other _____

Note: If you are a Medicare Retiree, you cannot enroll in both UMP and Medicare Part D. UMP provides your prescription drug coverage so there's no need for you to enroll in a Part D plan.

Persons covered by both UMP and other insurance:

Name:	**Date of birth:**	**Relationship to policyholder:**

(Please turn over)

Persons covered by both UMP and other insurance (cont.)

Please use the space below to add other coverages:

3. If natural parents of the children covered by UMP are separated or divorced, please complete this section.

Is there a court order mandating that healthcare coverage is provided for the children?

☐Yes (If yes, list the name of the person mandated and the names of the children the mandate applies to below.) ☐No (If no, complete Question 4.)

Name of person mandated: _____

Name of children mandate applies to:

_____ _____

_____ _____

_____ _____

4. If natural parents are separated or divorced, who has legal custody of dependent children?

Name of child:	**Who has legal custody?**
_____	☐Father ☐Mother ☐Joint ☐Other_____
_____	☐Father ☐Mother ☐Joint ☐Other_____
_____	☐Father ☐Mother ☐Joint ☐Other_____
_____	☐Father ☐Mother ☐Joint ☐Other_____

Your signature below certifies that the information you have entered on this form is true and correct to the best of your knowledge. You agree to contact us immediately should changes occur in other prescription coverage for you or your dependents.

_____ _____

Signature of UMP member/subscriber Date

_____ _____

E-mail of UMP member/subscriber Daytime phone of UMP member/subscriber

We appreciate the time you have taken to complete the information on this form. If you have any questions about the information contained in this letter, please contact ArrayRx at 1-888-361-1611 (TRS: 711).