Washington State Rx Services
P.O. 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 Washington State Rx services by mail or fax. You can also call us with the information at 1-888-361-1611 (TRS: 711).

Washington State Rx Services
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)

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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 Washington State Rx Services at 1-888-361-1611 (TRS: 711).

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

1-888-361-1611 (TRS: 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Washington State Rx Services
Attention: Appeal Unit
PO Box 40168
Portland, OR 97240-0168
Fax: 1-866-923-0412

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-888-361-1611 (TRS: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hổ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-888-361-1611 (TRS: 711)

注意：如果您說中文，可得到免費語言幫助服務。請致電 1-888-361-1611（聾啞人專用 TRS: 711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-888-361-1611 (TRS: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-888-361-1611 (TRS: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-888-361-1611 (الهاتف النصي TRS: 711)

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-888-361-1611 (TRS: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-888-361-1611 (текстовый телефон TRS: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-888-361-1611 (TRS: 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-888-361-1611 (TRS: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-888-361-1611 पर कॉल करें (TRS: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-888-361-1611 (TRS: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-888-361-1611（TRS:、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-888-361-1611 (TRS: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-888-361-1611 (TRS: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-888-361-1611 (TRS: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-888-361-1611 (TRS: 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-888-361-1611 (TRS: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-361-1611 (TRS: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-888-361-1611 (TRS: 711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-888-361-1611 (TRS: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-888-361-1611 (TRS: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-888-361-1611 (TRS: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-888-361-1611 (obsługa TRS: 711)