Coordination of Benefits Form

UPREHS Medicare Plans
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421
Fax number: 801-595-2039

ACTION REQUIRED! RETURN COMPLETED FORM TO UPREHS IMMEDIATELY!

Medicare law requires you to provide coordination of benefits information to us each year. You must complete this form and return it to Union Pacific Railroad Employes Health Systems annually or when there is a change. Medicare may have cause to disenroll you from UPREHS if we don't have current information. Complete the questionnaire below and return it to UPREHS by mail at UPREHS, PO Box 161020, Salt Lake City, UT 84116, or fax to 801-595-2039. If your Medicare spouse is covered by UPREHS, please complete the second set of identical questions for your spouse. For help call UPREHS Customer Services at 1-800-547-0421 Monday through Friday, from 7:30 am until 3:30 pm, MST.

Please Answer the Following Questions

As a member of the UPREHS Prime Medicare Plan, you can keep other current prescription coverage that you may already have including other private insurance, Workers Compensation, VA benefits, State assistance programs, and any other coverage you may have for your prescriptions. You can only have one Medicare Part D Plan. Medicare coordinates your benefits, so please list any current coverage you have for prescription drugs that you plan to keep in addition to your Part D UPREHS Prime Medicare Plan.

Member Name (please print) ______________________________ Phone (____) __________________

UPREHS ID Card # _________________________ Medicare # ________________________________

I plan to keep other prescription coverage in addition to UPREHS. ☐ Yes ☐ No

If you checked "yes", what is the name of your other coverage?_________________________________

What is your identification number (ID number) for this coverage? ______________________________

Please complete this section for your Medicare spouse (if covered by UPREHS)

Please list any current coverage you have for prescription drugs such as other private insurance, Workers Compensation, VA benefits, State assistance programs that you plan on keeping in addition to your UPREHS Prime Medicare Plan.

Spouse Name (please print) ________________________________ Phone (____)__________________

UPREHS ID Card # _________________________ Medicare # ________________________________

I plan to keep other prescription coverage in addition to UPREHS. ☐ Yes ☐ No

If you check "yes", what is the name of your other coverage? __________________________________

What is your identification number (ID number) for this coverage? ______________________________

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