STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
2024 SILVERSCRIPT PART D PRESCRIPTION DRUG PLAN HIGH-INCOME SURCHARGE VERIFICATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER

If you are covered as the spouse of an OGB plan member, enter their information below.

OGB PLAN MEMBER'S LAST NAME	OGB PLAN MEMBER'S FIRST NAME	OGB PLAN MEMBERS'S SSN

Each person covered by OGB's SilverScript Medicare Part D plan has a separate ID card that contains the member number for that person.

SILVERSCRIPT MEDICARE MEMBER #	OGB PLAN MEMBER'S SILVERSCRIPT MEDICARE ID #		
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

Your Monthly High-Income Part D Premium Surchage Amount (Select One):

☐ Deducted from your monthly Social Security check

☐ Invoiced to you by Centers for Medicare & Medicaid Services (CMS) every quarter or month

SIGNATURE _____ DATE _____

PRIMARY TELEPHONE NUMBER	ALTERNATE PHONE NUMBER
EMAIL ADDRESS	

Return this completed form and a copy of the Medicare letter that informed you of your Social Security benefit for the plan year to:

Office of Group Benefits
Attention: Customer Service
P.O. Box 44036
Baton Rouge, LA 70804-4036
Fax: 225-342-9919
email: ogb.customerservice@la.gov