Allina Health | Aetna Medicare 2026 Individual Enrollment Request Form Instructions

OMB No. 0938-1378 Expires 12/31/2026

How to enroll

Call us at: **1-844-622-5196 (TTY: 711)**	**Through your agent**: Give them the completed form	**Fax** to: Attention: Enrollment Department Fax: **1-844-749-2651**	**Mail** to: Allina Health | Aetna Medicare PO Box 14077, Lexington, KY 40512

Get ready

Have the following handy:

- Your red, white and blue Medicare insurance card
- Your health insurance information for any other insurance you have (including Medicaid)
- If you are an Allina Health | Aetna Medicare member now, or have been in the past, please have your Member ID number ready to include in the "Answer these important questions" section.
- Your primary care provider's information which is available online at **AllinaHealthAetnaMedicare.com/findprovider**

Questions?

Call us at **1-844-622-5196 (TTY: 711)**. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

Tips for your enrollment request

- Each applicant must complete their own enrollment. Please don't photocopy a form for reuse.
- **Please print neatly. Complete all sections**. Don't forget to sign and date the form.
- **For individuals experiencing homelessness**: If you want to join a plan but have no permanent residence, a Post Office Box, the address of a shelter or clinic, or the address where you receive mail (for example, Social Security checks) may be considered your permanent residence address.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see next page).
- Make a copy of the completed application for your records.
- We recommend you confirm your form was received if you fax or mail it (for example, call us to confirm receipt or send certified mail).

Thank you for choosing our plan. You'll hear from us within 10–14 days.

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Confirm your enrollment period

Typically, you may enroll in a Medicare Advantage Plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying, to the best of your knowledge, that you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Prospective member name	**Medicare Number** __ __ __ __ - __ __ __ - __ __ __ __

Reason for Annual Enrollment Period Eligibility

☐ I'm enrolling **between 10/15/25 and 12/7/25** during the current Annual Enrollment Period.

Reasons for Initial Enrollment Period Eligibility

☐ I'm new to Medicare.

☐ I'm new to Medicare, and I was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on __ __/__ __/__ __ (date).

☐ I had Medicare prior to now, but I'm now turning 65.

Reasons for Open Enrollment Period Eligibility

Between 1/1/26 and 3/31/26:

☐ I'm in a Medicare Advantage plan and want to make a change.

Between 4/1/26 and 12/31/26:

☐ I'm in a Medicare Advantage plan and have had Medicare for less than 3 months. I want to make a change.

Reasons for Special Enrollment Period Eligibility

☐ I moved to a new address that's outside my current plan's service area, or I recently moved and have new options available to me. I moved on __ __/__ __/__ __ (date).

☐ I was released from jail. I was released on __ __/__ __/__ __ (date).

☐ I moved back to the United States after living outside the country. I returned to the U.S. on __ __/__ __/__ __ (date).

☐ I recently got lawful presence status in the United States. I got this status on __ __/__ __/__ __ (date).

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on __ __/__ __/__ __ (date).

☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)). *(continued on the next page)*

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Prospective member name	Medicare Number __ __ __ __ - __ __ __ - __ __ __ __

Reasons for Special Enrollment Period Eligibility *(continued)*

- ☐ I recently had a change in my Extra Help paying for my drug costs (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on __ __/__ __/__ __ (date).
- ☐ I dropped my coverage in a PACE (Programs of All-Inclusive Care for the Elderly) plan on __ __/__ __/__ __ (date).
- ☐ I live in a long-term care facility, like a nursing home or a rehabilitation hospital.
- ☐ I recently moved out of a long-term care facility, like a nursing home or rehabilitation hospital. I moved out of the facility on __ __/__ __/__ __ (date).
- ☐ I lost other, non-Medicare drug coverage (creditable coverage), or my other non-Medicare coverage changed and is no longer considered creditable coverage. I lost my drug coverage on __ __/__ __/__ __ (date).
- ☐ I left coverage from my employer or union (including COBRA coverage) on __ __/__ __/__ __ (date).
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I am losing help from a State Pharmaceutical Assistance Program.
- ☐ I lost my coverage because my plan no longer covers the area that I live.
- ☐ I lost my coverage because Medicare ended its contract with my plan. I got a letter from Medicare saying I could join another plan. I lost my coverage on __ __/__ __/__ __ (date).
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on __ __/__ __/__ __ (date).
- ☐ I lost my Special Needs Plan because I no longer have a condition required for that plan. I was disenrolled from the plan on __ __/__ __/__ __ (date).
- ☐ I want to join a Special Needs Plan that tailors its benefits to my chronic condition.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency, or by Federal, my state or my local government). One of the other statements applied to me, but I was unable to make my request because of the disaster.

If none of these statements above apply to you, but you feel you have a special circumstance which allows you to enroll, you can call us at **1-844-622-5196 (TTY: 711)**. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. We can help you to determine if you qualify for a Special Election Period.

Otherwise, note the reason for your Special Election period below. Allina Health | Aetna Medicare may contact you to determine if you're eligible.

☐ Other SEP Reason: _____

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Allina Health | aetna

Agent Use Only:
Agent Name:
NPN#:

Enrollment Request Form

To enroll in an Allina Health | Aetna Medicare plan, please provide the following information:

Choose your plan

Check the plan you want to enroll in.

☐ *Allina Health Aetna Medicare Chronic (PPO C-SNP) (H3219-015)	**$0.00** per month
☐ *Allina Health Aetna Medicare Value (PPO C-SNP) (H3219-016)	**$41.50** per month

*Note: Plans with an asterisk (*) next to the plan name must have a Primary Care Provider (PCP) assigned. See the **Choose your Primary Care Provider (PCP)** information below.*

Proposed effective date of coverage: __ __ / __ __ / __ __
Effective dates are based on the enrollment period you're using to enroll and the Centers for Medicare & Medicaid Services' regulations. Unless you are new to Medicare or are eligible for a Special Election Period (SEP), your effective date will be January 1. Allina Health | Aetna Medicare cannot guarantee the effective date you've requested will be honored.

Choose your Primary Care Provider (PCP)

Some of our plans coordinate your care through a PCP. We have noted these plans with an asterisk (*) next to the plan name (*Example: "*Allina Health | Aetna Medicare (PPO)"*). If you selected a plan noted with an asterisk, and do not choose a PCP, we may not pay for your care and will assign a PCP to you. **Please note that a specialist is not considered a valid PCP selection.**

If the plan you have selected does NOT have an asterisk (*) next to the plan name, you still have the option to choose a PCP. When we know who your doctor is, we can better support your care.

Write in the **name, Provider ID** and **Primary Care ID** of your primary care provider (PCP) below. Visit our online provider directory at **AllinaHealthAetnaMedicare.com/findprovider** or call **1-844-622-5196 (TTY: 711)** to find provider information or a network PCP for your specific plan selection.

Full name of your PCP (first and last name)	**Are you a current patient?** ☐ Yes ☐ No
Provider ID (located in the provider directory)	☐☐☐☐☐☐☐
Primary Care ID (located in the provider directory)	☐☐☐☐☐☐

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Your information

Last name	First name	Middle initial

Birth date	Sex	Phone number
__ __ / __ __ / __ __ __ __ M M D D Y Y Y Y	☐ Male ☐ Female	(__ __ __) __ __ __ - __ __ __ __ Is this a mobile number? ☐ Yes ☐ No

Email address

Enter your permanent residence street address below - including Apt/Suite/Unit. Don't enter a PO Box unless you are experiencing homelessness.

☐ Check here if you are currently experiencing homelessness

Permanent residence street address

City	County	State	ZIP code

Mailing address - including Apt/Suite/Unit (if different from your permanent street address)

City	State	ZIP code

Your Medicare information

This information is on your red, white and blue Medicare insurance card

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

	Effective Date:
Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __	**HOSPITAL (Part A)** __ __ / __ __ / __ __ __ __
	MEDICAL (Part B) __ __ / __ __ / __ __ __ __

Answer these important questions

☐ Yes ☐ No

1. **Will you have other prescription drug coverage in addition to Allina Health | Aetna Medicare?** Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage: _____

   Group # for this coverage: _____

☐ Yes ☐ No

2. **Are you enrolled in your state's Medicaid program?**

   If "Yes," write in your Medicaid number: _____

☐ Yes ☐ No

3. **Are you a current or past Allina Health | Aetna Medicare member?**

   If "Yes," write in your Aetna Member ID number (12 digits beginning with "10"):

1	**0**										

All questions below are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Indicate your **preferred spoken language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

Indicate your **preferred written language** (if not English):

☐ Spanish ☐ Chinese ☐ Other (please specify):

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please call us at **1-844-622-5196 (TTY: 711)** if you need information in an accessible format other than what's listed above. We're here 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30.

Paying your plan premiums

Let us know how you want to pay your monthly plan premium (including any late enrollment penalty you may owe). Please select an option even if your plan has a $0 premium. If you don't select a payment option, we'll automatically send you an invoice each month.

☐ **Electronic Funds Transfer (EFT) from checking or savings account**

- You won't need to remember to send in a check each month.
- The money is automatically taken from your account on the 10th of each month (or the following business day).
- We will withdraw the total amount due on your account. This includes your current monthly premium payment, as well as any past due payments at the time of the monthly draft.

Please complete the following:

Account holder name: _____

(Print the name as it appears on the account to be debited.)

Bank name: _____

ROUTING NUMBER ☐☐☐☐☐☐☐☐☐

ACCOUNT NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ☐ Checking ☐ Savings

Signature of account holder: (if different than enrollee)

_____

I agree that this authorization will remain in effect until I provide written notification terminating this service.

☐ **Automatic deduction from my Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ☐ **Social Security** ☐ **RRB**

- **Do <u>not</u> select this option if:**
  - Another program (such as an Employer Group or State Pharmaceutical Assistance Program (SPAP)) is paying part of your premium.
  - You are enrolling in a plan with a $0 premium and you do not owe a late enrollment penalty.
  - You are enrolling in a Dual-Eligible Special Needs Plan (D-SNP) or an Institutional Special Needs Plan (ISNP).
- SSA/RRB will tell us when your premium deduction will start coming out of your SSA/RRB check (this could take up to 3 months). While we wait for your request to process, we'll send you an invoice to pay your premium.
- Sometimes SSA/RRB may not accept the request for deductions from your SSA/RRB check. If this happens, we'll send you an invoice to pay your monthly premium.

☐ **Monthly payments by invoice**

- You can mail us a check with your payment slip each month.
- You can go online and pay by debit or credit card after your enrollment in the plan is active.

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- You can bring your invoice to any CVS Pharmacy® and pay with cash, credit card, or debit card. (This service is not available at CVS Pharmacy at Target® or Schnucks Pharmacy locations.)

Additional notes about payment and options

- Social Security will contact you if you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA). You'll have to pay this extra amount as well as your plan premium. You will either have the amount withheld from your SSA or RRB benefit check, or be billed directly by Medicare or the RRB. **Do not send your Part D-IRMAA payment to us**.
- Written EFT terminations must be received before the 1st of the month of the EFT transaction. EFT transactions will occur on the 10th of the month in the amount of the balance due.
- If you owe a late enrollment penalty, you can pay the penalty by EFT, mail or have it taken out of your SSA or RRB benefit check.
- People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at **1-800-772-1213 (TTY: 1-800-325-0778)**. You can also apply for Extra Help online at **ssa.gov/medicare/part-d-extra-help**.
- If you qualify for Extra Help with your Medicare prescription drug costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Read this important information and sign below

- **If you currently have health coverage from an employer or union, joining Allina Health | Aetna Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Allina Health | Aetna Medicare**. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.
- I must keep both Hospital (Part A) and Medical (Part B) to stay in Allina Health | Aetna Medicare.
- By joining this Medicare Advantage plan, I acknowledge that Allina Health | Aetna Medicare will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on the next page).

PRIVACY ACT STATEMENT

- The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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- I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-For-Service (PFFS), MA Medical Savings Account (MSA) plans).

- **MA-only plans:** I understand that when my Allina Health | Aetna Medicare coverage begins, I must get all of my medical benefits from Allina Health | Aetna Medicare. **MA-PD plans:** I understand that when my Allina Health | Aetna Medicare coverage begins, I must get all of my medical and prescription drug benefits from Allina Health | Aetna Medicare. **All plans:** Benefits and services provided by Allina Health | Aetna Medicare and contained in my Allina Health | Aetna Medicare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Allina Health | Aetna Medicare will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. 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 from Medicare.

Allina Health | Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Signature	**Today's date** __ __ / __ __ / __ __ __ __

If you're an **authorized representative (such as a power of attorney)** filling out this form on behalf of the enrollee, you must sign above and provide the following information. **Note: Broker or agent may not sign for enrollee.**

Name	Address
Phone number (__ __ __) __ __ __ - __ __ __ __	Relationship to enrollee

For individuals helping an enrollee with completing this form

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping someone fill out this form (but not authorized to make decisions on behalf of the enrollee).

Name	Relationship to enrollee
Signature	National Producer Number (NPN) (Agents/Brokers only)

According to the Paperwork Reduction Act (PRA) of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "How to enroll" on the first page of this form to send your completed form to the plan.

Allina Health | Aetna® Medicare Prequalification Assessment Tool

IMPORTANT: You are enrolling in an Allina Health | Aetna Medicare Chronic Condition Special Needs Plan (C-SNP).

Our C-SNP is for people who have diabetes, congestive heart failure and certain cardiovascular disorders. Before we can enroll you in a C-SNP, we are required by the Centers for Medicare & Medicaid Services (CMS) to confirm with your provider that you have one of these conditions. **This is a two-step process.**

Step 1: Please fill out this form. Return it with your completed enrollment application. If you check the box for at least one condition, you may qualify for an Allina Health | Aetna Medicare C-SNP.

Step 2: We will confirm your qualifying condition within 30 days of your enrollment with your physician.

Note: Without provider verification of chronic condition within 60 days of enrollment, you will be involuntarily disenrolled from the plan.

Read the following statements carefully and check the box of the condition that applies to you. By checking a box, you certify that you have one of the covered chronic conditions required to join this type of plan. If we later determine that this information is incorrect, you may be disenrolled.

Applicant's chronic condition diagnosis (check at least one box below):

Has a provider ever diagnosed you with one or more of the following conditions?

☐ **Diabetes** (high blood sugar)	☐ **Chronic heart failure (CHF)** (heart is unable to pump blood as it should)	☐ **Cardiovascular disease:** ☐ Cardiac arrhythmias (irregular heartbeats) ☐ Coronary artery disease (blocked blood vessels in the heart) ☐ Peripheral vascular disease (poor circulation in the arms and legs) ☐ Valvular heart disease (damage of flaps in the heart that control blood flow)
☐ **I do not have any of these conditions.**		

Use and disclosure authorization

Completion of this form authorizes the disclosure of individually identifiable health information in accordance with federal laws concerning the privacy of such information.

By providing your signature below, you certify that you have been diagnosed with one or more of the chronic conditions necessary for enrollment in an Allina Health | Aetna Medicare Chronic Condition Special Needs Plan and authorize the provider(s) listed below to confirm this diagnosis so that Allina Health | Aetna Medicare can confirm your C-SNP enrollment.

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Applicant/Authorized representative — please complete all fields as applicable.

Applicant name (required):	Date of birth (required): __ __ / __ __ / __ __ __ __
Medicare number (required): __ __ __ __ - __ __ __ - __ __ __ __	Telephone number (required): (__ __ __) __ __ __ - __ __ __ __
Signature (required):	**Today's date:** __ __ / __ __ / __ __ __ __

If you are an authorized representative helping someone fill out this form, you must sign above and provide the information below.

Name:	Relationship to applicant:
Address:	Telephone number (required): (__ __ __) __ __ __ - __ __ __ __

Please provide the name of the provider(s) who can confirm your diagnosis below.

Provider #1 who can verify your chronic condition — (required)

Physician/Nurse practitioner/Physician assistant name (required):		
Office telephone number (required): (__ __ __) __ __ __ - __ __ __ __	Office fax number (optional): (__ __ __) __ __ __ - __ __ __ __	
Provider ID from the provider directory (if available for an in-network provider):	Primary care provider ID (if available for an in-network provider):	
Address line 1		
Address line 2		
City	State	ZIP code
Office email address (if available):		

Provider #2 who can verify your chronic condition (optional)

Physician/Nurse practitioner/Physician assistant name:		
Office telephone number: (__ __ __) __ __ __ - __ __ __ __	Office fax number: (optional) (__ __ __) __ __ __ - __ __ __ __	
Address line 1		
Address line 2		
City	State	ZIP code
Office email address (if available):		

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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AGENT USE ONLY

Agent/producer/broker/representative must complete this section

Applicant's name	
If you are the agent/producer/broker/employed sales representative, you must provide the following information and submit it with the completed application.	
☐ Yes ☐ No	Was the Scope of Appointment (SOA) completed? (The SOA must be agreed to by the Medicare beneficiary prior to any personal individual marketing appointment.) If "No," why not? : _____
☐ Yes ☐ No	Was the SOA captured electronically or by telephone? If "Yes," please provide the confirmation/ID number: _____ Attach the SOA or indicate why it's not available: _____
Name of agent/producer/broker/sales rep:	
Phone number:	National Producer Number (NPN):

☐ Check box if application received at a retail kiosk.

NOTE: If the agent/producer/broker/employed sales representative takes receipt of this application, a signature and date are REQUIRED below. Your signature indicates you understand that this application must be submitted within two calendar days of this date.	
Signature of agent/producer/broker/sales rep:	Date agent received the Individual Enrollment Request Form:

Copy and keep this completed form for your records. The completed election period checklist on page 1 must be included with the form.

Fax or mail the completed form to:
Aetna Medicare
PO Box 14077, Lexington, KY 40512
Fax: 1-844-749-2651

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Medicare Advantage Plan Enrollment Receipt

Agent/Broker: Complete and leave with enrollee.
Keep this as proof of your enrollment request until Medicare has confirmed your enrollment and you receive your member materials. This receipt is not a guarantee of enrollment.

This receipt is for your records only. No further action is necessary.

Applicant	
Name:	
Today's Date:	Proposed Effective Date:

Call your Agent/Broker if you have any questions	
Agent/Broker Name:	
Agent/Broker Phone Number:	Agent/Broker ID:

If you would like a complete copy of your enrollment form, call us at **1-800-562-6315 (TTY: 711)**, 8 AM to 8 PM, seven days a week, from October 1 to March 31 and 8 AM to 8 PM, Monday through Friday, from April 1 to September 30. Please allow at least 3 business days for us to process your application. **You'll need to provide your application tracking number, located at the bottom of this page.**

Reminder - Your enrollment request is for a **Medicare Advantage plan (Part C).** These plans:

- Replace Original Medicare that's provided by the federal government.
- Cover all your Part A and Part B benefits.
- Don't supplement your Original Medicare coverage like Medicare Supplement or Medigap plans.

Allina Health | Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Plan features and availability may vary by service area. Aetna® and CVS Pharmacy® are a part of the CVS Health® family of companies.

Application Tracking Number: JC26 1___/___/___
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