

**Humana.**

<PLAN NAME>

A Medicare Health Plan with Prescription Drug Coverage

**See Back for Dental**

CARD ISSUED: MM/DD/YYYY

**MEMBER NAME**

**Member ID: HXXXXXXXXX**

Plan (80840) 9140461101

RxBIN: XXXXXX

RxPCN: XXXXXXXX

RxGRP: XXXXX

Pharmacists: 1-800-865-8715

ANSI BIN # 610649

PCN # 03190000

**Medicare**<sup>Rx</sup>  
Prescription Drug Coverage  
CMS XXXX XXX



Set up your member account:

**Humana.com/myaccount**

Member/Provider Service:

1-800-457-4708 (TTY:711)

Suicide and Crisis Lifeline: 988

Pharmacist/Physician Rx Inquiries:

1-800-865-8715

IPA/Center Name:

XXXXXXXXXX

Primary Physician:

XXXXXXXXXXXXXXXXXX

Claims, PO Box 14601, Lexington, KY 40512-4601

For Dental: **Humana.com/sb**

Additional Benefits: DENXXX VISXXX HERXXX

EyeMed Vision:

XXX-XXX-XXXX