Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). **This payment option may help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

Complete all fields unless marked optional

FIRST name:	LAST name:	MIDDLE initial (optional):

Medicare Number: | | | | | - | | | | - | | | | | |

Member ID Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	RxGroup Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Birth date: (MM/DD/YYYY) (_____/_____/_____)	Phone number: (_____)

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City:	County (optional):	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):
Address: City: State: ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. [Plan Name (Plan Type)] will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the attached terms and conditions.
- **[Plan Name] will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

Signature:	**Date:**

If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant:

How to submit this form

You can also complete the participation request form online at https://www.express-scripts.com/mppp or call us at 1-833-750-9969 to submit your request via telephone.

Submit your completed form to:

Express Scripts MPPP
P.O. Box 801101
Kansas City, MO 64180-1101

If you have questions or need help completing this form, call us at 1-833-750-9969, 24 hours a day, 7 days a week. TTY users can call 1.800.716.3231.

TERMS AND CONDITIONS:

Upon acceptance into the Medicare Prescription Payment Plan:

- We will inform your pharmacy that you're using this payment option, which will apply only to Medicare Part D covered drugs that are processed after your election is confirmed.
- When you fill a prescription for an eligible drug, you will pay zero dollars at the pharmacy, but you will still be responsible for your cost share of the drug associated with your Medicare Part D benefit under your plan.
- You will receive a monthly invoice for the amount you owe, when it's due, and information on how to make a payment.
- Your payments may change every month because your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year. However, you'll never pay more than the total amount you would have paid out of pocket or the total annual out-of-pocket maximum.
- If you miss a payment, you will receive a reminder notice. If you don't pay your bill by the date listed, you will be removed from this payment option. However, you are required to pay the amount you owe, and you may not be able to elect back into this payment option.
- You can leave this payment option at any time without affecting your Medicare drug coverage and other Medicare benefits.
- You can do this by selecting Opt-out through the website or calling the phone number listed on the back of your member ID card. However, after you opt out, you will receive an invoice each month for the amount you owe until your balance is paid.
- You'll pay the pharmacy directly for new out-of-pocket drug costs after you leave this payment option.
- Participation in this payment option will automatically make you eligible for important relevant emails.
- If you are disenrolled from your Medicare Part D plan for any reason, or you enroll in a new plan with drug coverage, your participation in this payment option will end. However, you will continue to receive a monthly invoice for the amount owed until your balance is paid in full. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.
- While this payment option helps to manage your costs, it doesn't lower your costs. If you have limited income or resources, you can learn more about programs to help lower drug costs by visiting Medicare.gov.
- If you have a concern, you have the right to follow the grievance process found in your Member Handbook or Evidence of Coverage.
- Express Scripts is administering this program on behalf of your Medicare Part D plan. If your address is different than what is on the form, you will need to work with your plan to update your address.
- If you suspect that your account or password has been compromised, please notify Express Scripts.
- Express Scripts works with a third-party supplier to offer the Medicare Prescription Payment Plan, including providing a website to view your account, schedule and make payments, and review payment history.
- I understand that my plan, Express Scripts and other third parties on behalf of them may contact me, by phone or text at the phone numbers I provide in conjunction with my coverage. I acknowledge these calls or text messages may be delivered using an automated system. I understand I can opt out of calls and texts related to the Medicare Prescription Payment Plan by contacting Express Scripts or my health plan at any time.