Humana®

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is an **optional** 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 might 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: _____ Humana ID: H _____

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. Humana 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.
- **Humana 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 complete the participation request form online by visiting **Humana.com/MPPP** or scan this QR code to opt into the program.

To submit your request via telephone, call us at the number on the back of your ID card.

For questions or help completing this form, you can call us seven days a week, from 8 a.m. – 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays.

To submit this form by mail, send to:

Medicare Prescription Payment Plan
PO Box 14540
Lexington, KY 40512-4540