CarePlus HEALTH PLANS

# 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: CarePlus ID:

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:

I want to participate in the Medicare Prescription Payment Plan for the:

☐ Current Plan Year ☐ Upcoming Plan Year

## Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. CarePlus 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.
- **CarePlus 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.
- I understand that if I stay in the same health or drug plan, CarePlus will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact CarePlus to opt out.

**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

**CarePlusHealthPlans.com/MPPP** or scan this QR code to opt into the program.

To submit your request via telephone, call CarePlus Member Services at **800-794-5907 (TTY: 711).**
For questions or help completing this form, please call our Member Services Department at 800-794-5907. If you use a TTY, call 711. You can call us seven days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at CarePlusHealthPlans.com.

To submit this form by mail, send to:
Medicare Prescription Payment Plan
CarePlus Health Plans, Inc.
PO Box 14540
Lexington, KY 40512-4540