Capital

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 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

NAME First:		**Last:**	**Middle Initial:**
Medicare Number	____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____		
Birth Date: (MM/DD/YYYY)	__ __ / __ __ / __ __ __ __	**Phone Number**	(__ __ __) __ __ __ - __ __ __ __
Permanent Residence Street Address (don't enter a P.O. Box unless experiencing homelessness):		**County** (Optional):	
Apt #:	**City:**	**State:**	**ZIP:**
Mailing address, if different from your permanent address (P.O. Box allowed):			
Apt #:	**City:**	**State:**	**ZIP:**

Read and Sign Below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Capital Blue Cross 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.
- **Capital Blue Cross 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 First:	**Last:**	**Middle Initial**

Street Address:			
Apt #:	**City:**	**State:**	**ZIP:**

Phone Number:	( )	**Relationship To Participant:**	

How to Submit This Form:

Submit your completed form to:

MPPP Election Dept.
Mailstop: 1001
13900 N. Harvey Ave
Edmond, OK 73013

Fax: 440.557.6525
Email: ElectMPPP@RxPayments.com

You can also complete the participation request form online at Activate.RxPayments.com, or call us at 833.696.2087 (TTY 711) to submit your request via phone.

If you have questions or need help completing this form, call us at 1-833-696-2087 (TTY 711). We are available 8:00 AM to 1:00 AM EST 7 days a week from October 1st through December 7th. From December 8th through March 31st, we will be available from 8:00 AM to 11:00 PM EST 7 days a week. From April 1st through September 30th, we will be available from 8:00 AM to 11:00 PM EST Monday thru Friday.

Terms and conditions for participation in the Medicare prescription payment plan

1. No fees or interest
The Medicare prescription payment plan does not charge any fees or interest, and no credit check is required to enroll in the program.

2. Notification to pharmacy
Upon acceptance into the Medicare prescription payment plan, we will inform your pharmacy that you are using this payment option.

3. Applicability
This payment option applies only to Medicare Part D covered drugs processed after your election is confirmed.

4. Cost sharing
When you fill a prescription for an eligible Part D drug, you will pay zero dollars at the pharmacy. However, you will still be responsible to pay your cost share of the drug through a monthly invoice.

5. Monthly invoices
Each month, you will receive an invoice detailing the out-of-pocket amount you owe, the due date, and information on how to make a payment. Monthly payments are required while you carry a balance, but you can pay the balance in full at any time.

6. Calculation of monthly payments
The formula for calculating the minimum monthly payment (referred to as the “maximum monthly cap”) differs for the first month of participation versus the remaining months of the plan year. The maximum monthly cap calculations include specifics of a participant’s Part D drug costs (previously incurred costs and new out-of-pocket costs), as well as the number of months remaining in the plan year and the amount outstanding. As such, the amount can vary from person to person and month to month, and the total outstanding balance will be completely paid off by January 31st of the calendar year immediately following the plan year in which you are an enrollee.

7. Missed payments
If you miss a payment, you will receive a reminder notice. If you do not pay your bill by the date listed in the reminder notice, you will be given 60 days grace period before you are removed from the Medicare prescription payment plan. However, you will still be required to pay the amount you owe and may not be able to re-enroll in the Medicare prescription payment plan.

8. Opting out
You can leave the Medicare prescription payment plan at any time by selecting the opt-out option through the website or by calling 833.696.2087 (TTY 711). After you opt out, you will continue to receive an invoice each month for the amount you owe until your balance is paid in full.

9. Communications and notifications
If you provide an email, participation in this program will automatically make you eligible for important emails containing information related to the Medicare prescription payment plan.

10. Disenrollment and new plan enrollment
If you are disenrolled from your plan for any reason or enroll in a new plan with drug coverage, your participation in this plan's Medicare prescription payment plan will end. However, you will continue to receive an invoice each month for any outstanding amounts until your balance is paid in full. You remain responsible for the amount due under this Medicare prescription payment plan. 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.

11. Address updates

Any contact information or communication preferences you provide during election or directly through your Medicare prescription payment plan portal will only be used for your Medicare prescription payment plan and may not be communicated to your Medicare Part D plan.

12. Communications

By providing us with your contact information, you consent to our contacting you by any means you have provided regarding important information about your Medicare prescription payment plan account. This consent allows us to use text messaging for informational and account service calls, but not for telemarketing or sales calls. This may also include contact from companies working on our behalf to service your account.