

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] 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:
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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](https://www.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.

ATTENTION: If you need help in your language, call 1-844-428-2224 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-844-428-2224 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-844-428-2224 (TTY: 711). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-844-428-2224 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-844-428-2224 (TTY՝ 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Չանզանահարեք 1-844-428-2224 (TTY՝ 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电 1-844-428-2224 (TTY: 711)。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电 1-844-428-2224 (TTY: 711)。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電 1-844-428-2224 (TTY: 711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 1-844-428-2224 (TTY: 711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-844-428-2224 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ। 1-844-428-2224 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫਤ ਸੇਵਾਵਾਂ ਹਨ।

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-844-428-2224 (TTY: 711) पर कॉल करें। विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं। 1-844-428-2224 (TTY: 711) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-844-428-2224 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-844-428-2224 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は 1-844-428-2224 (TTY : 711) までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。1-844-428-2224 (TTY : 711) にお電話ください。これらのサービスは無料です。

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-844-428-2224(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-844-428-2224(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-844-428-2224 (TTY: 711). ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສໍາລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ. ໃຫ້ໂທຫາ 1-844-428-2224 (TTY: 711). ບໍລິການເຫຼົ່ານີ້ຟຣີ.

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-844-428-2224 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnavg mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-844-428-2224 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-844-428-2224 (TTY: 711) ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្នាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-844-428-2224 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-844-428-2224 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-844-428-2224 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-844-428-2224 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-844-428-2224 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-844-428-2224 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-844-428-2224 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-844-428-2224 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-844-428-2224 (TTY: 711). Libre ang mga serbisyong ito.

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร 1-844-428-2224 (TTY: 711) นอกจากนี้ ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ โปรดโทร 1-844-428-2224 (TTY: 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-844-428-2224 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-844-428-2224 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-844-428-2224 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-844-428-2224 (TTY: 711). Các dịch vụ này miễn phí.