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 EPIC (New York's State Pharmaceutical Assistance Program/SPAP for short). Call us at 1-888-807-5717 (TTY 711), 24 hours a day, 7 days a week for more information.

Complete all fields unless marked optional

FIRST name:		LAST name:	MIDDLE initial (optional):
Medicare 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. Centers Plan for Healthy Living will contact me if they need more information. • I understand that signing this form means that I've read and understand the form. • Centers Plan for Healthy Living **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. • Please see additional terms and conditions on pages 3 and 4 of this form.	
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

Submit your completed form to:	You can also complete the participation request form **online** at mp.medimpact.com; or
Centers Plan for Healthy Living ATTN: M3P Election Form 75 Vanderbilt Avenue, Staten Island, NY 10304	**Call us** at 1-888-807-5717 (TTY 711), 24 hours a day, 7 days a week **to submit your request over the phone.**

If you have questions or need help completing this form, call us at 1-888-807-5717, 24 hours a day, 7 days a week. TTY users can call 711.

Medicare Prescription Payment Plan
Election Request Form Terms and Conditions

1. **Voluntary Participation.** Election in the Medicare Prescription Payment Plan (the "Program") is voluntary and not required to obtain prescription drugs under Medicare Part D.

2. **Medicare Part D Drugs Only**. The Program is only applicable for covered Medicare Part D drugs. The Program does not apply for drugs covered through Medicare Part A or Medicare Part B, medical benefits and/or services, or any other supplemental benefit.

3. **No Cost to Join.** The Program is completely free to join. Participants can opt-in without any upfront fees.

4. **Same Total Costs.** Election in the Program does not reduce the total cost of prescription drugs, nor does it reduce the amount of money that an individual pays in total out-of-pocket costs. Participants do not receive any discount for participating in the Program.

5. **No Interest or Additional Fees.** The Program does not include any interest or additional fees for spreading out payments.

6. **Notice of Acceptance of the Election Form.** To commence participation in the Program, the participant must receive an official "Notice to Acknowledge Acceptance of Election into the Medicare Prescription Payment Plan" via mail or electronically, depending on the participant's preferred and authorized communication method.

7. **Term of the Participation in the Program.** If the Election Form is accepted, the participant's election shall be in full force and effect for the Plan Year or remaining part of the Plan Year for which the election has been made, unless the election be previously voluntary or involuntary terminated as set forth herein.

8. **Debt Obligation.** Participation in the Program does not exempt the participant from their financial obligation. Any unpaid monthly payment remains a debt owed by the participant.

9. **Billing.** A participant opted into the Program will not pay out-of-pocket costs at the pharmacy (including mail-order and specialty pharmacies). The participant will get a bill each month from the health plan or the health plan's authorized vendor. The monthly bill is based on what the participant would have paid for any prescriptions they get, plus the previous month's balance, divided by the number of months left in the Plan Year.

10. **Monthly Payments are not fixed.** The monthly payments for a participant might change every month because new out-of-pocket drug costs get added into the monthly payment when filling a new prescription or refilling an existing prescription.

11. **Responsibility for Payments.** Participants are solely responsible for ensuring that all payments are made on time. Failure to make payments by the due date may result in termination from the Program.

12. **Grace Period.** A grace period of two months will be provided for late payments. The grace period begins on the first day of the month for which the balance is unpaid or the first day of the month following the date on which the payment is requested, whichever is later.

13. **Involuntary Termination.** If payments are not made by the end of the grace period, termination from the Program will occur as of the first day of the month following the end of the grace period.

14. **Opting Out/Voluntary Termination.** Participants may opt out of the Program at any time during the Plan Year. Upon opting out, the participant will pay any new out-of-pocket costs directly to the pharmacy. The Participant will also be responsible for paying any remaining balance either by one lump sum or finishing its monthly payments.

15. **Modifications.** Participants will be notified of any changes to the payment plan terms and conditions, including any changes to payment amounts, due dates, or other relevant information. Such notifications will be provided in a timely manner.

16. **Privacy and Data Security.** All personal and payment information provided by participants will be kept confidential and used solely for the purposes of administering the Program. The privacy and security of participants' information will be treated in accordance with applicable laws and regulations.

17. **Dispute Resolution.** Any disputes arising from the Program will be resolved in accordance with the health plan's established Medicare Part D appeals and grievance procedures.

18. **Contact information.** For questions or assistance with the Program, participants should contact Member Services at 1-888-807-5717. People with hearing impairments may call (TTY 711). Operating Hours are: 24 hours a day, 7 days a week for more information.