

1) Log in to MedImpact Member Portal at <u>mp.medimpact.com</u> and click on "Create an account" if you do not yet have one

C	O 🔒 🖻 https://www.medi	npact.com/web/login	☆	⊵ ⊻ @
Medimpac	t			HOME CONTACT
	Sign in	A HEALTHIER, MORE INFORMED YOU Sign in. or create an account to find lower cost options and pharmacy benefits online or on the go.	manage your	
	USERNAME	DSNPTESTI	40000	4.
	PASSWORD Forg		Need help2	

2) Click on Medicare Prescription Payment Plan on the upper tab

$\leftarrow \rightarrow$ (ps://consumerportal. medin	npact.com/#/web/dashboard		☆	v 🖌 🔹 1
Hor	me My Prescriptions ~ My Be	nefits Documents v	Medicare Prescription Payment Plan		¢ ³ ⊭⁰	XXXXXCPL XX ~
Drug	Pricing Pharmacy Search	Enter Drug Name	City.	State or Zip Code	◀ Locate Me	Search
	Welcome XXXXXCPL			Ø DASHBOARD SETTINGS	Refill A Pro	escription

3) You will be redirected to Medicare Prescription Payment Plan Portal. Click on "Opt-In" option on the right side:

CENTERS PLAN FOR HEALTHY LIVING	comput memoraneoutrageoocor	Home Opt-In	Invoice Payment	s Prescriptions Documents	9 ×
	1602900201	Current Invoice		Medicare Prescription Payment Opt Status	
MBI Date of Birth 456789101 01/01/1925	Total out-of-pocket cost incurred	Invoice Amount : \$0.00 Due Date : -		Opt status - A Member not opte	d in
Full Name XXXXXCPL XXXXH6988002RI	As on 11/11/2024	View Invoice Detail	Pay Now	View Opting History	Opt-In

4) Only fields marked a with red asterisk are required. If there is no authorized rep, then skip these questions and click "Next"

Opt-In				
Status Start Date *				
01/01/2025				
Authorized Rep Details				
First Name		Last Name		
Enter max 24 characters	\otimes	Enter max 35 characters	\otimes	
Street		City		
Enter max 50 characters	\otimes	Enter max 40 characters	\otimes	
State		Zip Code		
	\otimes		\otimes	
Phone Number		Relationship to participant		
	\otimes	Select Relationship	•	
	Cancel	Clear Next		1/2

5) Uploading documents is not required. However, you MUST click on terms and conditions in order to proceed further.

	Drag & drop files or <u>Browse</u> Supported formats:pdf	
cuments Uploaded)
lo Files Selected		
gnature Date		
/11/2024		

6) The following screen pops up, so you need to read and click "Accept"

Terms And Conditions
 I understand that as a participant of this voluntary payment option, I will receive a monthly invoice for the amount I owe for prescriptions filled. I understand that payment will be due by the date indicated on the monthly invoice. I understand that I will be removed from the Medicare Prescription Payment Plan (involuntarily termed) if the payment for past due amounts is not received by the end of the grace period. When my participation ends, I will be responsible for paying the pharmacy directly for all new out-of-pocket drug costs. I understand that I can leave the Medicare Prescription Plan at any time (voluntarily term). If I still owe a balance, I am required to pay the amount I owe, even though I am no longer participating in this payment option. I understand that regardless of how my participations ends, I will continue to receive monthly invoices for prescriptions filled during my participation in the payment option until all amount owed is paid. I understand that if I am removed from the Medicare Prescription Payment Plan, I will NOT be able to use this payment option in the future until the amount owed has been paid.

7) Then click on "Submit"

11/11/2024		
1	Conditions.	
I agree to the Terms an	Conditions	

8) Click "Yes"



9) Your confirmation code pops up, please write it down in case you need it in the future:

