

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):
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Medicare Number:	Presbyterian Member ID:
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Birth date: (MM/DD/YYYY)	Phone Number:
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Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

City:	County (optional):	State:	ZIP code:
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Mailing address, if different from your permanent address (P.O. Box allowed):

Address:	City:	State:	ZIP code:
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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. _____ will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- _____ **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, _____ will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact _____ to opt out.

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 complete the participation request form online at phs.org/myrx or call us at **1-866-528-5829** to submit your request. Submit your completed form to:

Capital Rx
Attn: Medicare Prescription Payment Plan Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, OR 97008-7105

If you have questions or need help completing this form, call us at **1-866-528-5829**, 24 hours a day, seven days a week. TTY users can call **711**.

Terms and Conditions

You attest and understand you must be a Medicare Part D member to participate in this program. You acknowledge and agree your participation in the Medicare Prescription Drug Plan (MPPP) program is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS). CMS may adjust the MPPP program requirements at any time, and you acknowledge that such changes may impact your standing in the MPPP program, how the MPPP program may work, or other aspects of the program. When you participate in the MPPP, you agree to the repayment of any and all applicable prescription costs incurred during your participation in the MPPP program. You further acknowledge your private information, including protected health information, may be securely communicated to contracted third-party entities to provide you with certain services or functions of the MPPP program. See Capital Rx's Privacy Policy at www.cap-rx.com/legal#legal-notice-privacy-policy for more information. When utilizing any of the MPPP digital platforms, you understand that the contents, logo and other visual media created is property of its respectful owner and is protected by copyright laws.

Nonpayment of premiums or Part D Late Enrollment Penalties to Presbyterian Health Plan may result in involuntary disenrollment. To help avoid this, we may reallocate payments made to your Prescription Payment Plan to cover outstanding amounts and prevent or delay disenrollment. If you have questions or need assistance, please contact us at **(505) 923-6060** or **1-800-797-5343**.

The information on this request form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.

SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'j' ahoot'i'ígíí éí t'áá jiiik'eh hóló. Kohji' 1-855-592-7737 (TTY: 711) hodílnih doodago nika'análwo'í bich'j' hanidziih.

For more information, visit <https://www.phs.org/nondiscrimination>.