PRESBYTERIAN
Health Plan, Inc.

Presbyterian Senior Care (HMO) / (HMO-POS)
Presbyterian Dual Plus (HMO D-SNP)
Presbyterian UltraFlex (HMO-POS)

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 spreadingthem 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: __ __ __ __ -__ __ __ - __ __ __ __	Presbyterian Member ID:
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. **Presbyterian Senior Care (HMO) / (HMO-POS), Presbyterian Dual Plus (HMO D-SNP), or Presbyterian UltraFlex (HMO-POS)** will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Presbyterian Senior Care, Presbyterian Dual Plus, or Presbyterian UltraFlex 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 signaturecertifies 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 via telephone. Submit your completed form to:

Capital Rx
Attn: Medicare Prescription Payment Plan Elections9450
SW Gemini Dr., Suite 87234
Beaverton, Oregon 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 youacknowledge 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 communicated to third-party entities to provide you with certain services or functions of the MPPP program. See Capital Rx's Privacy Policy at **https://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 itsrespectful 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 toll free at 1-800-797-5343.

The information on this request form is correct to the best of my knowledge. I understand that if lintentionally 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 Committeefor Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.

Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but notlimited to race, color, national origin, age, disability, or sexual orientation or gender expression. If you need language assistance, services are available at no cost. Call (505) 923-5420, 1-855-592-7737 (TTY: 711).

ATENCIÓN: Si usted prefiere hablar en español, están a su disposición servicios gratuitos de ayuda lingüística. Llame al(505) 923-5420, 1-855-592-7737 (TTY: 711).

D77 baa ak0 n7n7zin: D77 saad bee y1n7łti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih (505) 923-5420, 1-855-592-7737 (TTY: 711).

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