network health

# Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan 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 a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

## Complete all fields unless marked optional

I want to participate in the Medicare Prescription Payment Plan for the:
☐ Current Plan Year ☐ Upcoming Plan Year

| 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. My plan 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.
- **My plan will 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, my plan will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact my plan to opt out.

| **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:

Express Scripts MPPP
P.O. Box 801101
Kansas City, MO 64180-1101

You can also complete the participation request form online at **https://www.express-scripts.com/mppp** or call us at **1.866.845.1803** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1.866.845.1803**, 24 hours a day, 7 days a week. TTY users can call **1.800.716.3231**.

**KEEP THIS PAGE FOR YOUR RECORDS**

## Medicare Prescription Payment Plan Terms and Conditions

By opting into the Medicare Prescription Payment Plan, you agree to the following terms and conditions:

1. **We'll Let Your Pharmacy Know**
   We'll notify your pharmacy that you're using this payment option. It will apply only to Medicare Part D covered drugs that are processed after your participation request is approved.
2. **This Payment Plan Spreads Out Costs—It Doesn't Lower Them**
   While this payment option helps to manage your drug costs, it does not lower your drug costs. If you have limited income or resources, visit Medicare.gov to learn about programs that can help lower your drug costs.
3. **You Pay $0 at the Pharmacy (You'll Be Billed Later)**
   When you get a prescription filled for an eligible drug, you won't pay anything at the pharmacy. But you will still be responsible for your share of the cost of the prescription covered by your Medicare Part D benefit under your plan. Before you pick up your prescription, make sure you understand how much you'll need to pay each month for the rest of the year. The pharmacy can help you understand your share of the prescription cost.
4. **You'll Get a Monthly Bill**
   Each month, you'll receive a bill for the amount you owe, when it's due, and information on how to make a payment.
5. **Your Monthly Payment May Change**
   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. But you'll never pay more than the total amount you would have paid out of pocket or the total annual out-of-pocket maximum.
6. **If You Miss a Payment**
   If you miss a payment, you'll get a reminder notice. If you don't pay your bill by the due date listed, you'll be removed from this payment option. You're still required to pay the amount you owe, and you may not be able to elect back into this payment option.
7. **If Your Medicare Part D Plan Changes**
   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. But you'll still continue to get a monthly bill for the amount you owe 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.
8. **Automatic Renewal**
   I understand that if I stay in the same health or drug plan, my plan will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact my plan to opt out.
9. **You Can Opt Out Anytime**
   You can leave this payment plan at any time without affecting your Medicare drug coverage and other Medicare benefits.
10. **How to Opt Out of the Payment Plan**
    You can opt out online through the website or by calling the phone number listed on the back of your member ID card. After you opt out, you'll still get a bill each month for the amount you owe until your balance is paid.

11. **Paying After You Opt Out**
    You'll pay the pharmacy directly for new out-of-pocket drug costs after you leave this payment plan.
12. **Have a Concern?**
    If you have a concern, you have the right to file a complaint. Follow the grievance process found in your Member Handbook or Evidence of Coverage for how to do that.
13. **Address Changed?**
    Express Scripts administers this program for your Medicare Part D plan. If your plan has a different address than the one filled out on the form, you'll need to contact your plan to update your address.
14. **Online Account Access**
    Express Scripts works with a third-party supplier to offer the Medicare Prescription Payment Plan, to give you a website to view your account, schedule and make payments, and review your payment history. You can go to this website at **https://www.express-scripts.com/mppp**.
15. **Protect Your Account**
    If you suspect that your online account or password has been compromised, call Express Scripts right away.
16. **You'll Get Important Emails**
    By participating in this payment option, you'll automatically receive important relevant emails from Express Scripts or its delegate.
17. **Phone Calls and Texts**
    I understand that my plan, Express Scripts and other third parties on their behalf 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.
18. **Who Manages This Payment Plan?**
    Express Scripts, Evernorth's pharmacy benefit services business, administers this program for your prescription plan for your employer, plan sponsor, health plan, or benefit fund.