

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

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: _____

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. PrimeTime Health 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.
- **PrimeTime Health 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, PrimeTime Health Plan will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact PrimeTime Health 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:

Optum Rx
Attn: M3P Election Processes
PO BOX 650287
Dallas, TX 75265-0287

You can also complete the participation request form online at **m3p-form.optumrx.com**, or call **1-844-368-8729** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-844-368-8729**, 5:00 a.m CST - 10:00 p.m CST, 7 days a week free. TTY users can call **711**.

Terms and Conditions

The Medicare Prescription Payment Plan is a new payment option in the Inflation Reduction Act. It 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). Your drug coverage offers this payment option and participation is voluntary. There is no extra cost to join.

By joining the Medicare Prescription Payment Plan, you agree to these terms and conditions:

- You must have active Part D coverage.
- You can leave the Medicare Prescription Payment plan at any time, but you will still be responsible for any drug costs already incurred.
- You will be billed monthly. This payment is separate from any plan premiums (if applicable).
- Your payments may change each month if your prescriptions change.
- You must pay your bill each month, on or before the due date.
- If you miss a payment, you will get a reminder. If you do not pay your bill by the due date in the reminder, you may be removed from the Medicare Prescription Payment Plan.
- You agree to receive phone calls, including autodialed and prerecorded calls, at the telephone number(s) you provided to your health plan. Calls may contain personal health information. You may opt out of receiving telephone calls at any time.
- Removal from the Medicare Prescription Payment Plan does not change your payment requirements. If you are removed, you still must pay past due amounts and may continue to receive bills for outstanding payments.
- Late payments made pursuant to the Medicare Prescription Payment Plan are not subject to interest or additional fees.
- If you are removed from the Medicare Prescription Payment Plan, this will not impact your current drug coverage.
- Removal from the Medicare Prescription Payment Plan may impact your eligibility to enroll in the program in the future.



Members were selected to receive this communication based on pharmacy claims data. Information in this letter is confidential and not shared with any non-medical personnel or personnel not directly managing pharmacy claims. Medications listed in this letter are subject to change. Please visit **optumrx.com** for the most current formulary information.

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