

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

Important Note: If "Current Plan Year" is selected than your participation will begin immediately and will automatically renew for the upcoming plan year if you stay in the same health or drug plan.

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Blue Cross Blue Shield of Kansas 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.
- **Blue Cross Blue Shield of Kansas 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, Blue Cross Blue Shield of Kansas will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Blue Cross Blue Shield of Kansas 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:

Blue Cross Blue Shield of Kansas
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, OR 97008-7015

Email: M3P-Election@judi.com

You can also complete the participation request form online at www.myprime.com, or call us at 833-247-0541 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-247-0541, 24 hours a day/7 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 Payment Plan program is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS). CMS may adjust the Medicare Prescription Payment Plan program requirements at any time, and you acknowledge that such changes may impact your standing in the Medicare Prescription Payment Plan program, how the Medicare Prescription Payment Plan program may work, or other aspects of the program. When you participate in the Medicare Prescription Payment Plan, you agree to the repayment of any and all applicable prescription costs incurred during your participation in the Medicare Prescription Payment Plan 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 Medicare Prescription Payment Plan program.

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