# 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) |
|---|---|---|
| | | |

| **Birth date** (MM/DD/YYYY) | **Sex** | **Phone number** |
|---|---|---|
| (  /  /  ) | ☐ M ☐ F | (  )  - |

**Permanent residence street address** (don't enter a P.O. Box)

| City | County (optional) | State | ZIP code |
|---|---|---|---|
| | | | |

**Mailing address, if different from your permanent address** (P.O. Box allowed)

| City | State | ZIP code |
|---|---|---|
| | | |

## Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Arkansas Blue Medicare will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- Arkansas Blue Medicare 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** (MM/DD/YYYY) |
|---|---|
| | |

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**<br>(  )  - | **Relationship to participant** |

## How to submit this form

**Submit your completed form to:**

> Arkansas Blue Medicare
> Medicare Prescription Payment Plan
> P.O. Box 7
> Pittsburgh, PA 15230

You can also complete the participation request form online at **arkansasbluecross.com/mppp** or call us at **1-844-280-5833** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-844-280-5833**, 24 hours a day, seven days a week. TTY users can call **711**.

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The Medicare Prescription Payment Plan is a voluntary program that allows members to spread their out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect plan premiums, which are billed and should be paid separately. By opting in to the program, the member (or the member's authorized representative) is indicating they understand these Medicare Prescription Payment Plan terms and conditions. The member is agreeing to be financially responsible for all amounts billed under the program. A member who does not pay the amounts due under the program will be terminated from the program and will not be allowed to opt in again until the amounts owed are repaid in full. Members can choose to opt out of the program at any time, however, any outstanding amounts owed will continue to be billed and must be paid.

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