simply Prescriptions
PO Box 211316
Eagan, MN 55121

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 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: _ _ _ _ - _ _ _ - _ _ _ _	**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. Simply Prescriptions 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.
- ☐ **Simply Prescriptions 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 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:

Simply Prescriptions
ATTN: SURVEY SERVICES
PO BOX 41911
ROCHESTER, NY 14604-9909

You can also complete the participation request form online at www.simplyprescriptions.com, or call us at 1-877-883-9577 to submit your request via telephone.

If you have questions or need help completing this form, please call our Customer Care Department at 1-877-883-9577. Hours are Monday through Friday, 8:00 am to 8:00 pm. From October 1 - March 31, hours are Monday through Sunday, 8:00 am to 8:00 pm. TTY users should call 1-800-662-1220.

Address Update:

☐ Check box if your permanent address has changed.

☐ Check box if your mailing address has changed.

Terms & Conditions of the Medicare Prescription Payment Plan

Once you receive notice of your acceptance into the Medicare Prescription Payment Plan, your election request is effective. Once effective, the Health Plan will pay the pharmacy directly for your prescription drug claims. By opting into Medicare Prescription Payment Plan, you agree to the following Terms and Conditions:

HOW YOU WILL BE BILLED

The Health Plan will send you a bill each month. This Medicare Prescription Payment Plan bill will be separate from your plan premium if you have one. In the Medicare Prescription Payment Plan, each month you will pay your plan premium (if you have one) and you will get a bill from us for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

WHEN PAYMENT IS DUE

Payments will be due on the due date of each bill.

ACCEPTABLE PAYMENT METHODS

You can pay:

- Through the mail by check or money order to P.O. Box, Binghamton, NY 13902-5267
- By setting up automatic payments through an electronic funds transfer

WHAT HAPPENS IF PAYMENTS ARE MISSED

You will receive a reminder if you miss a payment. Your participation with us in this Medicare Prescription Payment Plan program may be terminated. Removal from Medicare Prescription Payment Plan does not mean removal from your Medicare plan. Also, you will still be responsible for paying the total amount due after a failure to pay on the payment plan.

WHAT IF PAYMENTS ARE MADE TO MEDICARE PRESCRIPTION PAYMENT PLAN WHEN PREMIUMS TO YOUR MEDICARE ADVANTAGE PLAN HAVE NOT BEEN PAID

If you are delinquent on payment of your Medicare Advantage plan premiums, the Health Plan will apply payments made to the Medicare Prescription Payment Plan plan to your Medicare Advantage plan premiums.

CAN I LEAVE MEDICARE PRESCRIPTION PAYMENT PLAN?

You can leave Medicare Prescription Payment Plan at any time. If you still owe a balance, you are required to pay the amount you owe, even though you are no longer participating in the program.

WHAT HAPPENS IF I LEAVE OR CHANGE MEDICARE PRESCRIPTION DRUG PLANS?

If you leave or change Medicare Prescription Drug Plans, your participation in Medicare Prescription Payment Plan will automatically end with the Health Plan. If you still owe balance to the Health Plan you agree to pay the amount owed. After opting out, you agree to pay any new out-of-pocket costs directly to the pharmacy.

HOW TO ADDRESS CONCERNS WITH MEDICARE PRESCRIPTION PAYMENT PLAN

You have the right to follow the grievance process found in your Evidence of Coverage (EOC) as appropriate.