Medicare Prescription Payment Plan participation request form

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:

Do you get help paying your prescription drug costs from a program like Medicare's Extra Help, a State Pharmaceutical Assistance Program (SPAP), Indian Health Services, or other health insurance?
☐ Yes ☐ No ☐ Not sure

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. <Plan Name> 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 (if included)>.
- **<Plan Name> 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:**

Name: Address (Street, City, State, ZIP code):

Phone number: ( ) Relationship to participant:

How to submit this form

Submit your completed form to:

<Plan Name>
<Plan address>
<Plan address>
<Plan address>
<Plan fax number if applicable>
<Plan email if plan chooses to accept forms via email>

<Plans can insert their Medicare Prescription Payment Plans terms and conditions on the back of this form or attach them separately>