simply Prescriptions

PO Box 211316
Eagan, MN 55121

For Internal Use

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:

Select the year you would like to opt in: ☐ Current Year ☐ January 1st of the New Year*

* The January 1st option is only available between October 15th through December 31st.

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.
- I understand that if I stay in the same health or drug plan, Simply Prescriptions will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Simply Prescriptions to opt out.

Signature: **Date:**

Please turn page over.

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 simplyprescriptions.com/PrescriptionPayment, 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.