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):
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		

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Highmark Health Options Duals (HMO SNP) 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.
- **Highmark Health Options Duals (HMO SNP) 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:

Highmark Health Options Duals (HMO SNP)
Medicare Prescription Payment Plan
P.O. Box 7
Pittsburgh, PA 15230

You can also complete the participation request form online at https://www.highmark.com/health-options-de, or call us at 1-833-957-0025 (TTY: 711) to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-833-957-0025, TTY users can call 711,

8 a.m. - 8 p.m. Eastern Time 7 Days a week from October 1 through March 31.
* From April 1 through September 30 our business hours are 8 a.m. - 8 p.m., Monday through Friday.

Medicare Prescription Payment Plan Terms and Conditions

The Medicare Prescription Payment Plan is a voluntary program that allows you to spread your out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect your total prescription cost. Any applicable plan premiums are billed and should be paid separately from your Medicare Prescription Payment Plan billing statement. By opting in to the program, you (or your authorized representative) are indicating you understand these Medicare Prescription Payment Plan terms and conditions. You are agreeing to be financially responsible for all amounts billed under the program. If you do not pay the amounts due under the program, you will be terminated from the program and will not be allowed to opt in again until the amounts owed are repaid in full. You 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.