Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan 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. Ultimate Health Plans, Inc 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.
- **Ultimate Health Plans, Inc will 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, Ultimate Health Plans, Inc will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Ultimate Health Plans, Inc to opt out.

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:

Optum Rx
Attn: M3P Election Processes
PO BOX 650287
Dallas, TX 75265-0287

You can also complete the participation request form online at **m3p-form.optumrx.com/?cid=ulthp**, or call **1-844-368-8729** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-844-368-8729**, 5:00 a.m CST - 10:00 p.m CST, 7 days a week. TTY users can call **711**.

Terms and Conditions

The Medicare Prescription Payment Plan is a new payment option in the Inflation Reduction Act. It 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). Your drug coverage offers this payment option and participation is voluntary. There is no extra cost to join.

By joining the Medicare Prescription Payment Plan, you agree to these terms and conditions:

- You must have active Part D coverage.
- You can leave the Medicare Prescription Payment plan at any time, but you will still be responsible for any drug costs already incurred.
- You will be billed monthly. This payment is separate from any plan premiums (if applicable).
- Your payments may change each month if your prescriptions change.
- You must pay your bill each month, on or before the due date.
- If you miss a payment, you will get a reminder. If you do not pay your bill by the due date in the reminder, you may be removed from the Medicare Prescription Payment Plan.
- You agree to receive phone calls, including autodialed and prerecorded calls, at the telephone number(s) you provided to your health plan. Calls may contain personal health information. You may opt out of receiving telephone calls at any time.
- Removal from the Medicare Prescription Payment Plan does not change your payment requirements. If you are removed, you still must pay past due amounts and may continue to receive bills for outstanding payments.
- Late payments made pursuant to the Medicare Prescription Payment Plan are not subject to interest or additional fees.
- If you are removed from the Medicare Prescription Payment Plan, this will not impact your current drug coverage.
- Removal from the Medicare Prescription Payment Plan may impact your eligibility to enroll in the program in the future.