CommuniCare ADVANTAGE

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 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: _ _ _ _ - _ _ _ - _ _ _ _		
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. CommuniCare Advantage 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.
- CommuniCare Advantage **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, CommuniCare Advantage will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact CommuniCare Advantage 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:

CommuniCare Advantage
10123 Alliance Rd., Suite 240
Blue Ash, OH 45242
FAX: (513) 605-6845
Email: ISNPSales@chs-corp.com

You can also complete the participation request form online at Medicare Prescription Payment Plan - CommuniCare Advantage, or call us at (866) 212-4582 (TTY/TDD 711) to submit your request via telephone.

If you have questions or need help completing this form, call us at (866) 212-4582. We are open October 1 to March 31, from 8:00 a.m. to 8:00 p.m., seven days a week (except Thanksgiving and Christmas) and from April 1 to September 30, 8:00 a.m. to 8:00 p.m., Monday through Friday (except holidays). TTY/TDD users can call 711.

Medicare Prescription Payment Plan Terms & Conditions

The Medicare Prescription Payment Plan is a new payment option within the Inflation Reduction Act. The Medicare Prescription Payment Plan works with your CommuniCare Advantage drug coverage to help manage out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January through December). Participation in the program is voluntary and there is no additional cost to participate in the Medicare Prescription Payment Plan.

By opting into the Medicare Prescription Payment Plan, you agree to the following terms and conditions:

- You must be enrolled in a Part D coverage plan.
- You understand that the Medicare Prescription Payment Plan provides the option to pay your out-of-pocket prescription drug costs in monthly installments over the course of the plan year, instead of paying the entire out-of-pocket costs at the pharmacy.
- You understand that participating in the Medicare Prescription Payment Plan is voluntary and you have the option to leave the Medicare Prescription Payment Plan at any time.
- You understand that leaving the Medicare Prescription Payment Plan does not eliminate your responsibility to pay for prescription drug costs already incurred.
- You will receive a bill from us each month for drug costs you wish to be spread over the calendar year. This payment is separate from any plan premiums (if applicable).
- Your payments may change each month if your prescriptions change month over month. You are responsible for paying your bill each month, on or before the due date.
- If you miss a payment, you will be sent a reminder to make your payment. If you do not pay your bill by the due date listed in the reminder, you will be subject to removal from the Medicare Prescription Payment Plan.
- Removal from the Medicare Prescription Payment Plan does not impact your payment requirements. If terminated from this program, you remain obligated to 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 enrollment in your current Part D drug plan.
- Removal from the Medicare Prescription Payment Plan may impact your eligibility to opt into the program in the future.