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:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. FirstMedicare Direct 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.
- **FirstMedicare Direct 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:

FirstMedicare Direct
Application Processing Center
3310 Fields South Drive
Champaign, IL 61822

You can also complete the participation request form online at **FirstMedicare.com**, or call **1-877-210-9167** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-877-210-9167**, daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends, April 1 to September 30. TTY users can call **711**.

Terms and Conditions

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

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

- You must have active Part D coverage.
- You understand that you have the option to leave the plan at any time but 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 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 payment. If you do not pay your bill by the due date listed in that 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 the 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 current drug coverage.
- Removal from the Medicare Prescription Payment Plan may impact your eligibility to opt-in in the program in the future.