Participation Request

Medicare Prescription Payment Plan

Instructions for Completing this Request

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), or if you enroll later in the calendar year (after September). Call the MVP Medicare Prescription Payment Plan help line at 1-844-889-9792 (TTY 711) for more information.

Reason for Request *(select one)*: ☐ **New Request** ☐ **Change to Existing Request** ☐ **Termination**

Section 1: Member Information

Complete all fields unless marked optional.

First Name	Last Name	Middle Initial (optional):

Medicare Number	Birthdate (MM/DD/YYYY)	Phone Number
____-____-____	(____/____/____)	( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

Street Address	City	State	Zip Code	County (optional)

Mailing address, if different from your permanent address (PO Box allowed):

Street Address	City	State	Zip Code

Section 2: Read and Sign Below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. MVP Health Care® (MVP) will contact me if they need more information
- I understand that signing this form means that I have read and understand the form and the Terms and Conditions
- I understand that I will receive both an automated confirmation phone call and written notice from MVP 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

By including my signature below, I attest that the information provided in this Request is true to the best of my knowledge.

Member Signature *Member Name (print)* *Signature Date*

If You Are Completing This Form For Someone Else, Complete the Section Below:

Your signature certifies that you are authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

First Name	Last Name	Middle Initial (optional)

Street Address	City	State	Zip Code

Phone number ( )	Relationship to participant

How to Submit This Form:

Print and mail this completed form to:

MVP HEALTH CARE

ATTN: MEDICARE ENROLLMENT DEPT - M3P

625 STATE STREET

SCHENECTADY NY 12301-2207

You can also elect to participate in the Medicare Prescription Payment Plan online.
Visit **mvphealthcare.com/RxPaymentPlan** to learn more. Or call us at **1-844-889-9792** to submit your request via telephone.

If you have any questions or need help completing this form, please call the MVP Medicare Prescription Payment Plan help line at **1-844-889-9792** (TTY 711). Representatives are available from 8 am–8 pm Eastern Time, seven days a week between October 1 and March 31. April 1–September 30, representatives are available Monday–Friday, 8 am–8 pm.

Terms and Conditions:

The Medicare Prescription Payment Plan is a voluntary program that allows members to spread their out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect plan premiums, which are billed and should be paid separately. By opting in to the program, the member (or the member's authorized representative) is indicating they understand these Medicare Prescription Payment Plan terms and conditions. The member is agreeing to be financially responsible for all amounts billed under the program. A member who does not pay the amounts due under the program will be terminated from the program and will not be allowed to opt in again until the amounts owed are repaid in full. Members 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.