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 does not 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

NAME First	**Last**	**MI** (Optional)
Medicare Number		
Birth Date (MM/DD/YYYY)		**Phone Number**
Permanent Residence Street Address (PO Box not allowed, unless experiencing homelessness)		**County** (Optional)
Apt #	**City**	**State**	**ZIP**
Mailing Address, if different from your permanent address (PO Box allowed)		
Apt #	**City**	**State**	**ZIP**

Plan Year Selection

I want to participate in the Medicare Prescription Payment Plan for the:

☐ Current Plan Year ☐ Upcoming Plan Year

Important Note: If “Current Plan Year” is selected then your participation will begin immediately and will automatically renew for the upcoming plan year If you stay in the same health or drug plan.

Read and Sign Below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Alameda Alliance for Health 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 attached terms and conditions.
- **Alameda Alliance for Health will let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I am not a participant in the Medicare Prescription Payment Plan.
- I understand that if I stay in the same health or drug plan, Alameda Alliance for Health will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Alameda Alliance for Health to opt out.

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.

NAME First	**Last**	**MI**

Address			
Apt #	**City**	**State**	**ZIP**

Phone Number		**Relationship to Participant**	

How to Submit This Form

Submit your completed form to:

Alameda Alliance for Health
Mailstop: 1003
MPPP Election Dept.
13900 N. Harvey Ave
Edmond, OK 73013

Fax: 440-557-6525
Email: ElectMPPP@RxPayments.com

You can also complete the participation request form online at Activate.RxPayments.com, or call us at 833-246-7626 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-246-7626, 8AM to 11PM EST 7 days a week from Dec 8 - Mar 31, 8AM to 11PM EST Mon – Fri from Apr 1 – Sept 30, 8AM to 1AM EST 7 days a week from Oct 1 - Dec 7. TTY users can call 711.