

## Medicare Prescription Drug 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 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:	M.I.: (optional)
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Medicare Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Birth Date (MM/DD/YYYY): ( _ / _ / ____ )	Phone Number: ( ____ ) - ____ - ____
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### Permanent Residence (Don't enter a PO Box. Note: For individuals experiencing homelessness):

Street Address:

City:	County (optional):	State:	ZIP Code:
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### Mailing Address, if different from your permanent address (P.O. Box Allowed):

Street Address:

City:	State:	ZIP Code:
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### Read and sign below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. eternalHealth 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.
- **eternalHealth 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 Drug Payment Plan.

Signature:	Date:
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**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):
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Phone Number: ( ____ ) ____ - ____	Relationship to participant:
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Important instructions for form submission and detailed terms and conditions can be found on the reverse side.

## 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 through your Optum Rx portal at [www.OptumRx.com/eternalHealth](http://www.OptumRx.com/eternalHealth).

You may also call us at **1 (800) 891-6989 (TTY users call 711)** to submit your request via telephone.

If you have questions or need help completing this form, call member services at **1 (800) 891-6989**, 24 hours/7days a week. **TTY users can call 711.**

## Terms and Conditions

The Medicare Prescription Payment Plan (M3P) 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 enrolling in the Medicare Prescription Payment Plan (M3P), you agree to the following terms and conditions:

- To enroll in the plan, 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 enroll in the program in the future.