FHCP Medicare

P.O. Box 9910, Daytona Beach, FL 32120

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. FHCP Medicare 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.
- FHCP Medicare **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:

Capital Rx
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, Oregon 97008-7105
Election requests can also be emailed to M3P-Election@cap-rx.com.

You can also complete the participation request form online at https://app.cap-rx.com/?client=fhcpmedicare or call us at 1-877-282-2779 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-877-282-2779, 24 hours a day, 7 days a week. TTY users can call 1-800-955-8770.

Terms and Conditions

- The program is free to join, there are no fees or interest charged under the program, and the program does not lower the amount of cost-sharing you owe for your Part D prescriptions.
- If you qualify for Low Income Subsidy (LIS), enrollment in LIS is more advantageous than participation in the Medicare Prescription Payment Plan.
- Payments are required to be through Automated Clearing House (ACH) deposits.
- You may opt out of the program at any time. If you opt out, you will still be responsible for paying any remaining balance.
- It is important to pay your bill monthly. Your participation in the Medicare Prescription Payment Plan will be terminated if you fail to pay your monthly billed amount before the end of the grace period.
- If you are disenrolled voluntarily or involuntarily from our Part D plan you will also be terminated from the Medicare Prescription Payment Plan. If you enroll in a different plan, you may opt into the Medicare Prescription Payment Plan under your new plan.
- We cannot require you to answer questions about or provide documentation to prove your ability to pay your Medicare Prescription Payment Plan balance as a condition of you participating in the Medicare Prescription Payment Plan. We also cannot obtain a copy of your credit report from a consumer reporting agency.
- The Part D appeals and grievance procedures will apply to the Medicare Prescription Payment Plan and are located in the Evidence of Coverage.
- For additional information regarding the Medicare Prescription Payment Plan, please contact 1-877-282-2779.