COMMUNITY HEALTH CHOICE

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. Community Health Choice (HMO D-SNP) 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.
- **Community Health Choice (HMO D-SNP) 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:

Community Health Choice (HMO D-SNP)
Capital Rx
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, Oregon 97008-7105
M3P-Election@cap-rx.com

You can also complete the participation request form online at http://app.cap-rx.com/?client=communityhealthchoice, or call us at 1-833-463-0683 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-833-463-0683, 24 hours a day, 7 days a week. TTY users can call 711.

Medicare Prescription Payment Plan Terms and Conditions

You attest and understand you must be a Medicare Part D member to participate in this program. You acknowledge and agree your participation in the Medicare Prescription Payment Plan (MPPP) program is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS). CMS may adjust the MPPP program requirements at any time, and you acknowledge that such changes may impact your standing in the MPPP program, how the MPPP program may work, or other aspects of the program. When you participate in the MPPP, you agree to the repayment of any and all applicable prescription costs incurred during your participation in the MPPP program. You further acknowledge your private information, including protected health information, may be communicated to third-party entities to provide you with certain services or functions of the MPPP program. See Capital Rx's Privacy Policy at https://www.cap-rx.com/legal#legal-notice-privacy-policy for more information. When utilizing any of the MPPP digital platforms, you understand that the contents, logo and other visual media created is property of its respectful owner and is protected by copyright laws.