Providence
Medicare Advantage Plans

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 PO Box unless you're experiencing homelessness) ____________________

City ____________________

County (Optional) ____________________

State ____________________

ZIP Code ____________________

Mailing address, if different than from your permanet address (PO Box allowed) ____________________

City ____________________

State ____________________

ZIP Code ____________________

Read and sign below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Providence Medicare Advantage Plans will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Providence Medicare Advantage Plans 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 **Today's 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 compelted 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: **www.ProvidenceHealthAssurance.com/M3P**, or call us at **1-855-742-2779 (TTY: 711)** 24 hours a day, 7 days a week, to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-855-742-2779**, 24 hours a day, 7 days a week. TTY users can call 711.