

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. SimplicityRx 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.
- **SimplicityRx 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, SimplicityRx will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact SimplicityRx 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:

SimplicityRx
Mailstop: 1004
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](https://www.Activate.RxPayments.com), or call us at 1-833-246-6565 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-833-246-6565 October 1–December 7, 8 a.m. to 1 a.m. ET, seven days a week; December 8–March 31, 8 a.m. to 11 p.m. ET, seven days a week; April 1–September 30, 8 a.m. to 11 p.m. ET, Monday through Friday. TTY users can call 711.

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Terms and Conditions for Participation in the Medicare Prescription Payment Plan

The Terms and Conditions listed below outline your rights, responsibilities, and the rules governing participation in the Medicare Prescription Payment Plan program. By agreeing to these Terms and Conditions—either online, over the phone or by signing and returning the election form—you confirm that you understand and accept the provisions of the program.

1. **No Fees or Interest**

The Medicare Prescription Payment Plan does not charge any fees or interest, and no credit check is required to enroll in the Program.

2. **Notification to Pharmacy**

Upon acceptance into the Medicare Prescription Payment Plan, we will inform your pharmacy that you are using this payment option.

3. **Applicability**

This payment option applies only to Medicare Part D covered drugs processed after your election is confirmed.

4. **Cost Sharing**

When you fill a prescription for an eligible Part D drug, you will pay zero dollars at the pharmacy. However, you will still be responsible to pay your cost share of the drug associated with your Medicare Part D benefit under your plan that can be paid through a monthly invoice.

5. **Monthly Invoices**

Each month, you will receive an invoice detailing the out-of-pocket amount you owe, the due date, and information on how to make a payment. Monthly payments are required while you carry a balance, but you can pay the balance in full at any time.

6. **Calculation of Monthly Payments**

The formula for calculating the minimum monthly payment (referred to as the “maximum monthly cap”) differs for the first month of participation versus the remaining months of the year. The maximum monthly cap calculations include specifics of a participant’s Part D drug costs (previously incurred costs and new out-of-pocket costs), as well as the number of months remaining in the plan year and the amount outstanding. As such, the amount can vary from person to person and month to month, and the total outstanding balance will be completely paid off by February 1st of the next calendar year.

7. **Missed Payments**

If you miss a payment, you will receive a *Notice of Failure to Pay*. If you do not pay the outstanding amount due by the date listed in the reminder notice, you will be removed from the Medicare Prescription Payment Plan. However, you will still be required to pay the amount you owe and may not be able to re-enroll in the Medicare Prescription Payment Plan.

8. **Opting Out**

You can leave the Medicare Prescription Payment Plan at any time by selecting the opt-out option through the website or by calling the phone number provided to you in the *Notice of Election Approval* letter, which will be sent to you by your plan after successful election into the program. After you opt out, you will continue to receive an invoice each month for the amount you owe until your balance is paid in full.

9. Digital Communications and Notifications

If you provide an email, participation in this Program will automatically make you eligible for important emails containing information related to the Medicare Prescription Payment Plan.

10. Disenrollment and New Plan Enrollment

If you are disenrolled from your plan for any reason and/or enroll in a new plan with drug coverage, your participation in the Medicare Prescription Payment Plan through your current plan will end. However, you will continue to receive an invoice each month for any outstanding amounts until your balance is paid in full. You remain responsible for the amount due under this Medicare Prescription Payment Plan. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.

11. Address Updates

Any contact information or communication preferences you provide during election or directly through your Medicare Prescription Payment Plan online portal will only be used for your Medicare Prescription Payment Plan, and may not be communicated to your Medicare Part D plan. If you also need to make an address update for your Part D coverage then you will need to provide those directly to your Plan.

12. Communications

By providing us with your contact information, you consent to our contacting you by any means you have provided regarding important information about your Medicare Prescription Payment Plan account. This consent allows us to use text messaging for informational and account service calls, but not for telemarketing or sales calls. This may also include contact from companies working on our behalf to service your account.

13. Automatic Participation Renewal

Your participation in the Medicare Prescription Payment Plan will automatically renew for the following calendar year, unless you are enrolling in a new Medicare Part D plan or have opted out of the program prior to the beginning of the calendar year.