CenCal CareConnect

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 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:

I want to participate in the Medicare Prescription Payment Plan for the:

☐ Current Plan Year ☐ Upcoming Plan Year

Read and sign below

- **I understand this form is a request to participate in the Medicare Prescription Payment Plan. CenCal CareConnect 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.**
- **CenCal CareConnect will 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.**
- **I understand that if I stay in the same health or drug plan, CenCal CareConnect will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact CenCal CareConnect to opt out.**

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:

CenCal CareConnect
4050 Calle Real
Santa Barbara, CA 93110

You can also complete the participation request form online at www.cencalhealth.com/careconnect, or call us at 833-726-0676 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-726-0676, 7 day a week, 8 a.m to 8 p.m PT. TTY users can call CA Relay at 711.

Member ID: 123456789

Pharmacy Benefit Details:

Group: CEN10 BIN: 015574 PCN: ASPROD1
MPPP BIN: 027133 MPPP PCN: MPPPPROD1

CenCal CareConnect

Medicare Prescription Payment Plan
Election Request Form Terms and Conditions

1. I understand that I will pay $0 at the pharmacy, and my plan will send me a monthly bill for covered medication. I understand the Medicare Prescription Payment Plan (the Program) is only applicable for covered Medicare Part D drugs.
2. I understand that as a participant of this voluntary payment option, I will receive a monthly invoice for the amount I owe for prescriptions filled. I understand that payment will be due by the date indicated on the monthly invoice.
3. I understand my monthly payments might change every month because new out-of-pocket drug costs get added into the monthly payment when I fill a new prescription or refill an existing prescription.
4. I understand that when I join the Program, I agree to pay for my medication up to the Medicare Part D annual out-of-pocket maximum, for covered Medicare Part D drugs. I understand that my monthly bill is based on what I would have paid for any prescriptions I received, plus your previous month's balance, divided by the number of months left in the year.
5. I understand that I will be removed from the Program (involuntarily termed) if the payment for past due amounts is not received by the end of the grace period. When my participation ends, I will be responsible for paying the pharmacy directly for all new out-of-pocket drug costs. I understand that I can submit an inquiry or file a grievance to my plan.
6. I understand that I can leave the Program at any time (voluntarily term). If I still owe a balance, I am required to pay the amount I owe, even though I am no longer participating in this payment option.
7. I understand that leaving the Program, involuntarily or voluntarily, will not affect my Medicare Part D coverage with my Part D plan.
8. I understand that regardless of how my participation ends, I will continue to receive monthly invoices for prescriptions filled during my participation in the payment option until all amount owed is paid. I understand that I can pay the balance all at once or be billed monthly.
9. If you have limited income and resources or your financial situation has changed since choosing this payment option, you may be eligible for a program that can help lower your costs. Many people qualify for savings and don't realize it. Visit Medicare.gov/basics/costs/help or contact your local Social Security office to learn more. Find your local Social Security office at ssa.gov/locator/.