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:
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _	VERDA Member ID: _____	
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. VERDA Healthcare will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **VERDA Healthcare 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.

Verda Healthcare is an HMO with a Medicare contract. Enrollment in Verda Healthcare depends on contract renewal. Verda Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Every year, Medicare evaluates plans based on a 5-star rating system.

Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant:

How to submit this form:

You have alternative ways to elect to participate in the Medicare Prescription Payment Plan with Verda Healthcare:

TELEPHONE
1-877-419-2604 (TTY 711)

WEBSITE
www.verdahealthcare.com/mppp

MAIL Submit your completed form to:
Verda Health Plan
7755 Center Avenue, Suite 1200
Huntington Beach, CA 92647

VIA FAX AND E-MAIL
Fax: 1-714-845-9841
E-mail: mppp@verdahealthcare.com

You can also complete the participation request form online at www.verdahealthcare.com/mppp or call us at 1-877-419-2604 (Monday – Friday 8:00 am – 8:00 pm except major holidays. Between October 1st – March 31st, representatives are available Monday to Sunday 8:00 am – 8:00 pm). TTY users can call 711, to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-877-419-2604 (Monday – Friday 8:00 am – 8:00 pm except major holidays. Between October 1st – March 31st, representatives are available Monday to Sunday 8:00 am – 8:00 pm). TTY users can call 711.

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Terms and Conditions for Participation in the Medicare Prescription Payment Program (MEDICARE PRESCRIPTION PAYMENT PLAN)

1. No Fees or Interest
The Medicare Prescription Payment Program (MEDICARE PRESCRIPTION PAYMENT PLAN) is free to join and 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 Program, 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 drug, you will pay zero dollars at the pharmacy. However, you will still be responsible for your cost share of the drug associated with your Medicare Part D benefit under your plan that can be paid through a monthly invoice. The program does not lower the amount of cost-sharing you owe for your Part D prescriptions.

5. Monthly Invoices
Each month, you will receive an invoice detailing the 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. 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.

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, with the expectation that the total balance will be completely paid off by January 31st of the next calendar year.

7. Missed Payments
If you miss a payment, you will receive a reminder notice. If you do not pay your bill by the date listed in the reminder notice, you will be removed from the Medicare Prescription Payment Program. 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 Program.

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8. Opting Out
You can leave The Medicare Prescription Payment Program at any time by calling the phone number listed on the back of your member ID card. If you opt out, you will still be responsible for paying any remaining balance. 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. 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 Program.

10. Disenrollment and New Plan Enrollment
If you are disenrolled from your plan for any reason or enroll in a new plan with drug coverage, your participation in The Medicare Prescription Payment Program 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 Program. If you enroll in a new plan with drug coverage, you may be able to rejoin The Medicare Prescription Payment Program 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 will only be used for your Medicare Prescription Payment Plan Program and may not be communicated to your Medicare Part D plan. Please ensure you notify your Plan Sponsor as well.

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 Program 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.

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