Select Health

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current Select Health Medicare 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 Select Health Medicare for more information.

COMPLETE ALL FIELDS UNLESS MARKED OPTIONAL

First Name: _____ Middle Initial (optional): ____ Last Name: _____

Medicare Number: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Date of Birth (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):

_____

City: _____ County (optional): _____ State: _____ ZIP code: _____

READ AND SIGN BELOW

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Select Health will contact me if they need more information.
- I have read and understand the included information and the terms and conditions available at **selecthealth.org/m3p**.
- Select Health 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: _____

City: _____ State: _____ ZIP code: _____

Phone Number: (_____) _____ Relationship to participant: _____

HOW TO SUBMIT THIS FORM

Submit your completed form to:

Select Health Medicare
Attn: Pharmacy Services
P.O. Box 30196
Salt Lake City, UT 84130-0196
Fax at **801-442-0770**

You can also complete the participation request form online at **selecthealth.org/m3p**.

If you have questions or need help completing this form, call us at **855-442-9900** (TTY: **711**) during the following dates and times:
October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.

Outside of these hours of operation, please leave a message and your call will be returned within one business day.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting Select Health Medicare: **855-442-9900 (TTY: 711)** / Select Health: **800-538-5038**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電