

**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 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. Select Option® PDP 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.
- **Select Option 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 (Street, City, State, ZIP code): _____

Phone number: () _____ Relationship to participant: _____

How to submit this form

Submit your completed form to:
Select Option
PO Box 41535

Philadelphia, PA 19101-1535

You can also complete the participation request form online at ibxmedicare.com/ira, or call us at 1-888-678-7009 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-888-678-7009, 8 a.m. to 8 p.m., seven days a week. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. TTY users can call 711.

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