



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:
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Mailing address, only if different from your permanent residence address (P.O. Box allowed):

City:	State:	ZIP code:
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PLEASE READ AND SIGN BELOW:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Aspire Health 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.
- Aspire 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:

(Form Continues on Following Page)

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: Aspire Health
Attn: Prescription Drug Payment Plan
10 Ragsdale Drive, Suite 101
Monterey, CA 93940

You can also complete the participation form online at www.aspirehealthplan.org or call (888) 495-3160 (TTY 711) to submit your request via telephone.

If you have questions or need help completing this form, call us at (888) 495-3160. Our hours are: 8 a.m.–8 p.m. Monday through Friday from April 1 to September 30 and 8 a.m.–8 p.m. seven days a week October 1 to March 31 (except certain holidays). TTY users can call 711.

**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) 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 Aspire Health Plan that can be paid through a monthly invoice.
- 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.
- 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.

8. Opting Out: You can leave The Medicare Prescription Payment Program at any time by selecting the opt-out option through the website or by calling (855) 570-1600 or 888-495-3160 (TTY 711). 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 Aspire Health 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 Payment Portal will be used for your Medicare Prescription Payment Plan Program, and may be updated by contacting Aspire Health Plan members services.

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.