Medicare Prescription Payment Plan Participation Request Form

CareFirst Medicare Advantage

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.

HOW TO SUBMIT THIS FORM:

- **Online:** Complete this form online at **carefirst.com/myaccount**
- Mail: Submit your completed form to:
  - CareFirst BlueCross BlueShield Group Advantage (PPO)>
    PO Box 7
    Pittsburgh, PA 15230
- **Phone:** Call us at 888-970-0917 to submit your request via telephone or if you have questions or need help completing this form, 24 hours a day, 7 days a week.

COMPLETE ALL FIELDS UNLESS MARKED OPTIONAL

Last Name	First Name	MI
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	State	Zip Code
County (Optional)		
Mailing address, if different from your permanent address (P.O. Box allowed):		
City	State	Zip Code

READ AND SIGN BELOW

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. CareFirst BlueCross BlueShield Group Advantage (PPO) will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **CareFirst BlueCross BlueShield Group Advantage 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.

Last Name	First Name	MI

Address (Street)

City	State	Zip Code

Phone Number	Relationship to Participant