# Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is an **optional** 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 might 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 iCare at 800-777-4376 for more information.

## Complete all fields unless marked optional

FIRST name: ________________________ LAST name: _________________ MIDDLE initial (optional): _____

Medicare Number: C_____________________________

| Birth date: (MM/DD/YYYY)<br>(_____ /_____ /__________ ) | Phone number:<br>(_________ ) _______________________________ |
|---|---|

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. *i*Care 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.
- ***i*****Care 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

You can

- e**mail this completed PDF to the iCare Pharmacy Department** at pharmserv@icarehealthplan.org

**Or**

- **mail your completed form to:**

  iCare Health Plan

  Pharmacy Department

  1555 N RiverCenter Drive, Suite 206

  Milwaukee, WI 53212