



Medicare Prescription Payment Plan participation request form

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

COMPLETE ALL FIELDS UNLESS MARKED OPTIONAL

First Name _____ Middle Initial _____ Last Name _____

Medicare Number: ____ - ____ - ____

Date of Birth (MM/DD/YYYY) ____ / ____ / ____ Ph # (____) _____

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. Scripius will contact me if they need more information.
- I have read and understand the included information and the terms and conditions available at **scripius.org/medicare**.
- Scripius 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 (MM/DD/YYYY) ____ / ____ / ____

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.

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ County (optional) _____ State _____ Zip code _____

Ph # (_____) _____ Relationship to participant: _____

HOW TO SUBMIT THIS FORM

Submit your completed form to:

Scripius 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 **scripius.org/medicare**.

If you have questions or need help completing this form, call us at **888-999-3265** (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.

Scripius 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 Scripius Medicare: **888-999-3265** (TTY: **711**).

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