



## Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan 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 your plan for more information.

### Complete all fields unless marked optional

First Name: \_\_\_\_\_ Middle Initial (optional): \_\_\_\_\_ Last Name: \_\_\_\_\_

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: \_\_\_\_\_ County (optional): \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

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

City: \_\_\_\_\_ County (optional): \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

I want to participate in the Medicare Prescription Payment Plan for the:

Current Plan Year  Upcoming Plan Year

### 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 understand that signing this form means that I've read and understand the form and the attached terms and conditions available at [scripius.org/medicare](https://scripius.org/medicare).
- Scripius **will 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.
- I understand that if I stay in the same health or drug plan, Scripius will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Scripius to opt out.

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: \_\_\_\_\_

City: \_\_\_\_\_ County (optional): \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

### How to submit this form

Submit your completed form to:

Scripius 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](https://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 8:00 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 8:00 a.m. to 8:00 p.m.

Outside of these hours of operation, please leave a message and your call will be returned within one business day.

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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: **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