MyTru Advantage

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: 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:

Mailing address, if different from your permanent address (P.O. Box allowed):
Address: City: 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. MyTruAdvantage will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form. I have also read and understand the terms and conditions included below.
- **MyTruAdvantage 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, MyTruAdvantage will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact MyTruAdvantage 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 (Street, City, State, ZIP code):
Phone number:( )	Relationship to participant:

How to submit this form

MyTruAdvantage offers multiple ways for you to submit your participation request.

Submit your completed form to:

MyTruAdvantage
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, Oregon 97008-7105
M3P-Election@cap-rx.com

You can also complete the participation request form online at app.cap-rx.com/?client=MyTruAdvantage, or visit our website at https://www.mytruadvantage.com/medicare-prescription-payment-plan or call us at 1-833-502-2904 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-833-502-2904, 7 days a week, 24 hours a day. TTY users can call 711.

Member Terms and Conditions. You attest and understand that this is a request to participate in the Medicare Prescription Payment Plan and that you must be a Medicare Part D member to participate in this program. You acknowledge and agree your participation in the Medicare Prescription Payment Plan program is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS). CMS may adjust the Medicare Prescription Payment Plan program requirements at any time, and you acknowledge that such changes may impact your standing in the Medicare Prescription Payment Plan program, how the Medicare Prescription Payment Plan program may work, or other aspects of the program. When you participate in the Medicare Prescription Payment Plan you agree to the repayment of any and all applicable prescription costs incurred during your participation in the Medicare Prescription Payment Plan program. You further acknowledge your private information, including protected health information, may be securely communicated to contracted third-party entities to provide you with certain services or functions of the Medicare Prescription Payment Plan program. See MyTruAdvantage's Privacy Policy at https://www.mytruadvantage.com/medicare-prescription-payment-for more information. When utilizing any of the Medicare Prescription Payment Plan digital platforms, you understand that the contents, logo and other visual media created is property of its respectful owner and is protected by copyright laws.

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal. MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711). 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 1.844.425.4280 (TTY: 711)

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