Medicare Prescription Payment Plan
Participation request form (2027)

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 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):
Street Address:

City: State: ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan in 2027. FEP Medicare Prescription Drug Program (MPDP) will contact me if they need more information.
- I understand that signing this form means that I've read and understand this form and the attached terms and conditions.
- **FEP Medicare Prescription Drug Program (MPDP) 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, FEP Medicare Prescription Drug Program (MPDP) will automatically renew my participation in the Medicare Prescription Payment plan at the beginning of each calendar year, unless I contact FEP Medicare Prescription Drug Program (MPDP) 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

You can also complete the participation request form online at caremark.com/mppp,or call us at 1-888-338-7737 to submit your request via telephone.

Submit your completed form to:

FEP Medicare Prescription Drug Program (MPDP)
Medicare Prescription Payment Plan
P.O. Box 7
Pittsburgh, PA 15230

If you have questions or need help completing this form, call us at 1-888-338-7737 TTY users can call 711, 24 hours a day, seven days a week.

Medicare Prescription Payment Plan Terms and Conditions

The Medicare Prescription Payment Plan is a voluntary program that allows you to spread your out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect your total prescription cost. Any applicable plan premiums are billed and should be paid separately from your Medicare Prescription Payment Plan billing statement. By opting in to the program, you (or your authorized representative) are indicating you understand these Medicare Prescription Payment Plan terms and conditions. You are agreeing to be financially responsible for all amounts billed under the program. If you do not pay the amounts due under the program, you will be terminated from the program and will not be allowed to opt in again until the amounts owed are repaid in full. You can choose to opt out of the program at any time; however, any outstanding amounts owed will continue to be billed and must be paid.