of Tennessee

Medicare Prescription Payment Plan participation request form

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 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 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:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. BlueAdvantage (PPO)[SM] 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.
- **BlueAdvantage 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

Submit your completed form to:

ATTN: Medicare Prescription Payment Plan Election
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 5
Chattanooga, TN 37402-9923

You can also complete the participation request form online at **bcbst-medicare.com/m3p**, or call us at **1-800-831-2583** to submit your request via telephone.

If you have questions or need help completing this form, call us at Member Service: **1-800-831-2583**, From **Oct. 1 to March 31**, you can call us from 8 a.m. to 9 p.m. ET, seven days a week. From **April 1 to Sept. 30**, we're available from 8 a.m. to 9 p.m. ET, Monday through Friday. TTY users can call TTY **711**.

of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbstmedicare.com

Medicare Prescription Payment Plan Terms and Conditions

You've applied for a Medicare Prescription Payment Plan offered by BlueCross BlueShield of Tennessee (BlueCross) or BlueCare Plus Tennessee. BlueCross or BlueCare Plus Tennessee is responsible for:

- Processing election into the Medicare Prescription Payment Plan.
- Billing and collecting payments from you for the amount due.
- Ending your participation in the Medicare Prescription Payment Plan (when appropriate).

BY APPLYING FOR AND ENROLLING IN A MEDICARE PRESCRIPTION PAYMENT PLAN THROUGH BLUECROSS OR BLUECARE PLUS TENNESSEE, I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

1. Eligibility

- I'm eligible under state and federal law and the policies of my health plan. When this document says "my health plan," it means BlueCross or BlueCare Plus Tennessee.

2. Participation Requirements

- My election into the Medicare Prescription Payment Plan is subject to acceptance by my health plan.
- If my health plan asks for more documentation, I have 21 calendar days to give them complete information and documentation to show my eligibility for the Medicare Prescription Payment Plan.
- If my election is accepted by my health plan, they'll provide me with a start date (also called an "effective date") within 24 hours during the plan year or within 10 calendar days if the plan year has yet to begin.
- I'll promptly notify my health plan of any changes to my address.
- I may be excluded from participating in the Medicare Prescription Payment Plan if:
  - I'm not currently eligible for Medicare Part D prescription drug coverage.

- I don’t provide my health plan with the complete, accurate information and documentation needed to process my election into the Medicare Prescription Payment Plan.
- I have an unpaid balance from previous participation in a Medicare Prescription Payment Plan.

3. **Retroactive Election**

- If my health plan doesn’t process my election into the Medicare Prescription Payment Plan timely in accordance with CMS guidelines, my election will start on the date I would have first been eligible for it following my application.

4. **Payment and Related Terms**

- I agree to pay the monthly billed amount for the Medicare Prescription Payment Plan by the date specified in the bill.
- My health plan will bill me once a month. This bill will be separate from any amount owed for my monthly premium, if applicable.
- The amount of my monthly bill can change during my participation in the Medicare Prescription Payment Plan. My monthly bill is based on what I would have paid for any prescriptions, my previous month’s balance and any past due amount. My health plan will then divide that total amount by the number of months left in the year (January–December).

5. **Cancellation and Termination**

- I may leave the Medicare Prescription Payment Plan at any time by notifying my health plan. My coverage will end on the last day of the calendar month in which I notify them.

6. **Nonpayment of Medicare Prescription Payment Plan Monthly Payment**

- Nonpayment of my Medicare Prescription Payment Plan monthly payment doesn’t impact my plan coverage. As long as I continue to pay my plan premium (if I have one), I’ll still have drug coverage through my health plan.
- My health plan may cancel my Medicare Prescription Payment Plan participation for any of these reasons:
  - I fail to pay my health plan premiums.
  - I no longer have Medicare Part D prescription drug coverage.
  - I fail to pay the monthly amount due under the Medicare Prescription Payment Plan for my prescriptions by the end of the established grace period.

- I commit fraud.
- I misrepresent my eligibility for the Medicare Prescription Payment Plan.
- I misrepresent any information relevant to my enrollment in my health plan.
- I fail to comply in a material manner with the requirements of my health plan. This can include, but isn't limited to, moving outside of the health plan's service area or failing to comply with the health plan's policies and procedures. I may request a copy of any detailed enrollment, billing or payment policies and procedures from my health plan. These policies and procedures are considered to be a part of this Terms and Conditions agreement.

7. Amendments

- My health plan may amend these Terms and Conditions from time to time. If this happens, they'll notify me of what's changing and the effective date.

8. Appeals and Grievances

- If any issues arise from my participation in the Medicare Prescription Payment Plan that I disagree with, I may file an appeal or grievance with my health plan. To learn more about my member rights, I can go to **bcbstmedicare.com** or **bluecareplus.bcbst.com** and select **Member Rights** in the footer. I can also contact my health plan for help or to get more information about these processes and procedures.

9. Acceptance of This Agreement

- My signature on the Medicare Prescription Payment Plan participation request form or verbal consent given to my health plan is deemed to be acceptance of this agreement on behalf of myself.