CoxHealth Medicare Advantage
CMH Medicare Advantage
Phelps Health Medicare Advantage

Cox HealthPlans
CoxHealth
THINKING HEALTH FORWARD

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

Your Medicare Information

First name:	Last name:	MI (optional):

Medicare Number: ____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

Please locate the 11-digit alpha-numeric number on your Medicare Card. Example: 1HG7-DE5-WB72

Birth date: (MM/DD/YYYY)

(_____/_____/_____)

Phone number:

( )

Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):

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

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

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

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Cox HealthPlans 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.
- **Cox HealthPlans 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.

First name:	Last name:	MI (optional):

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

Phone number:

( )

Relationship to participant:

How to submit this form

Submit your completed form to:
Cox HealthPlans
P.O. Box 5750, Springfield, MO 65801
Fax: 417-269-2919

You can also complete the participation form by phone at 417-269-2909 or 1-855-752-3796 (TTY: 711) or online in your Member Portal. Your member portal is located on your plan website: CoxHealthMedicareAdvantage.com, CMHMedicareAdvantage.com, or PhelpsHealthMedicareAdvantage.org.

If you have questions or need help completing this form, we are able to assist you at 417-269-2909 or 1-855-752-3796 (TTY: 711), October 1 to March 31, seven days a week from 8 a.m. to 8 p.m. and April 1 to September 30, Monday through Friday from 8 a.m. to 8 p.m.

Terms and Conditions

Participation in the Medicare Prescription Payment Plan is voluntary. Beneficiaries can choose to opt in or out of the program at any time during the year. Beneficiaries may opt into the Medicare Prescription Payment Plan by sending a completed opt-in form to the Cox HealthPlans, by contacting the Cox HealthPlans by telephone, online using the plan's website, or at the pharmacy at point of sale. Requests to opt into or out of the Medicare Prescription Payment Plan must come from the beneficiary or their legal representative. Requests received from any other party will not be processed. If a beneficiary no longer wishes to participate in the Medicare Prescription Payment Plan, they must notify Cox HealthPlans to opt out. Beneficiaries will be billed on a monthly cadence. Beneficiaries will be terminated from the Medicare Prescription Payment Plan following two months of non-payment.