



IMPERIAL HEALTH PLAN
OF CALIFORNIA

Medicare Prescription Payment Plan Participation Request Form

Imperial Health Plan of California,
Inc. PO Box 60874
Pasadena, CA 91116

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. Imperial Health Plan of California, Inc. (HMO) (HMO SNP) 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 following terms and conditions:

You attest and understand 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 (MPPP) program is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS). CMS may adjust the MPPP program requirements at any time, and you acknowledge that such changes may impact your standing in the MPPP program, how the MPPP program may work, or other aspects of the program. When you participate in the MPPP, you agree to the repayment of any and all applicable prescription costs incurred during your participation in the MPPP program. You further acknowledge your private

information, including protected health information, may be securely communicated to third-party entities to provide you with certain services or functions of the MPPP program. See Capital Rx's Privacy Policy at <https://www.cap-rx.com/legal#legal-notice-privacy-policy> for more information. When utilizing any of the MPPP 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.

- **Imperial Health Plan 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

Mail: Submit your completed form to:

Capital Rx
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, Oregon 97008-7105

Email: Email the completed form to M3P-Election@cap-rx.com

Online: You can complete the participation request form online at <https://enrollment.cap-rx.com/?client=imperialhealthplan>

Phone: Call us at 833-463-1650 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-463-1650, We are open October 1 – March 31: Monday – Sunday from 8:00 am PST. – 8:00 pm PST. and April 1 – September 30: Monday – Friday from 8:00 am PST. – 8:00 pm PST., except holidays. TTY users can call 711.

Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal.

Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Imperial does not exclude anyone or treat them unfairly because of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-838-8271 (TTY: 711) or speak to your provider.