Blue Advantage
A Medicare Approved PPO

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: ☐☐☐☐ – ☐☐☐ – ☐☐☐☐	Blue Advantage Member ID: ☐☐☐☐☐☐☐☐☐☐☐☐		
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):			
City:	County (Optional):	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. Blue Advantage (PPO) 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.**
• **Blue Advantage (PPO) 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, Blue Advantage (PPO) will automatically renew my participation in the Medicare Prescription Payment Plan, at the beginning of each calendar year, unless I contact Blue Advantage (PPO) 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.

First Name:	Last Name:	
Address:		
City:	State:	Zip Code:
Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐	Relationship to Participant:	

How to submit this form

Mail:	Phone:	Email:
Blue Advantage **Attn: M3P Elections** **9450 SW Gemini Dr. Suite 87234** **Beaverton, Oregon, 97008-7105**	**1-833-246-9619**	After completing this form, email it to: **M3P-Election@judi.com**

You can also complete the participation request online after logging into **BCBSALMedicare.com/M3P**, or call us at 1-833-246-9619, 24 hours a day, 7 days a week to submit your request via telephone. TTY users can call 711.

If you have questions or need help completing this form, call us at 1-833-246-9619, 24 hours a day, 7 days a week. TTY users can call 711.

Blue Advantage (PPO) is provided by Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

Terms and Conditions for Participation in the Medicare Prescription Payment Plan

The Terms and Conditions listed below outline your rights, responsibilities and the rules governing participation in the Medicare Prescription Payment Plan program. By agreeing to these Terms and Conditions—either online, over the phone or by signing and returning the election form—you confirm that you understand and accept the provisions of the program.

Medicare Part D Member – You attest and understand you must be a Medicare Part D member to participate in this program.

Voluntary Participation – You acknowledge and agree your participation in the Medicare Prescription Payment Plan is not required by law and is a voluntary program managed by the Centers for Medicare & Medicaid Services (CMS).

Requirement Changes – CMS may adjust the Medicare Prescription Payment Plan requirements at any time, and you acknowledge that such changes may impact your standing in the Medicare Prescription Payment Plan, how the Medicare Prescription Payment Plan may work, or other aspects of the program.

Prescription Costs Balance – 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.

Judi Rx Privacy Policy – 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. See Judi Rx's Privacy Policy at **https://www.judi.health/legal/privacy-policy** for more information.

Digital Platform Copyrights – 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.