KAISER PERMANENTE®

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 Kaiser Permanente for more information.

Complete all fields unless marked optional

Please indicate which Kaiser Permanente **region** you currently reside in:

☐ **CALIFORNIA** ☐ **COLORADO** ☐ **GEORGIA** ☐ **HAWAII** ☐ **MID-ATLANTIC STATES** ☐ **NORTHWEST** ☐ **WASHINGTON**

FIRST name: LAST name: MIDDLE initial (optional):

Medicare Number: Kaiser Permanente Medical/Health Record 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. Kaiser Permanente will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Kaiser Permanente 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:**

Y0043_H8794_N00038935_C
1377081729 (10/2024)

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:

Kaiser Permanente – Medicare Unit
P.O. Box 232400
San Diego, CA 92193-2400

You can also FAX or EMAIL your completed form to:

FAX: **1-855-355-5334**
EMAIL: **KPMedicareEnrollments@kp.org**

You can also complete the participation request form online at **kp.org/rxpaymentplan**, or at **kp.org/rxpaymentplanwa** if you are located in the Washington region, or call us at the phone number listed below for your region to submit your request via telephone.

You can check the progress of your participation request form online at **kp.org/medicare/applicationstatus** (does not apply to Washington region).

If you have questions or need help completing this form, call us at the phone number listed below for your region, 7 days a week, 8 a.m. to 8 p.m. TTY users can call **711**.

California: **1-800-443-0815**
Colorado: **1-800-476-2167**
Georgia: **1-800-232-4404**
Hawaii: **1-800-805-2739**

Maryland/Virginia/Washington, D.C.: **1-888-777-5536**
Oregon and SW Washington: **1-877-221-8221**
Washington: **1-888-901-4600**
(Counties: Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Grays Harbor (ZIP codes: 98541, 98557, 98559, 98568), and Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592))