

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 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 ☐ NEVADA ☐ 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):

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 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, Kaiser Permanente will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Kaiser Permanente 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.

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 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**.

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**

Nevada: **1-888-775-7003**

Oregon and SW Washington: **1-877-221-8221**

Washington: **1-888-901-4600**

(Counties: King, Kitsap, Lewis, Pierce, Snohomish, Spokane, Thurston, Grays Harbor (ZIP codes: 98541, 98557, 98559, 98568), and Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592))