

Section 1 – All fields on this page are required (unless marked optional):

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 (SPA). 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 number (don't enter a P.O. Box unless you're experiencing homelessness):		
City:	State:	Zip Code:
Mailing address, if different from your permanent address (PO Box allowed):		
Street address: City	State:	Zip Code:

Read and sign below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Florida Complete Care will contact me if they need more information.
- I understand that signing this form means that I've read and understand the terms and conditions.
- **Florida Complete Care 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.

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

You can also find the participation request form online at <https://fc2healthplan.com/>, or call us at 1-833-FC2-PLAN (1-833-322-7526), TTY users call 711 to submit your request via telephone.

Submit your completed form via mail, fax or email to:

Florida Complete Care
ATTN: Member Services
PO Box 667870
Miami, Florida 33166

Fax: 305-402-8178
Email: FC2MEMBERS@ilshealth.com

If you have questions or need help completing this form, call us at 1-833-FC2-PLAN (1-833-322-7526), TTY users can call 711, 7 days per week from 8am to 8pm from October 1st through March 31st and Monday through Friday 8am to 8pm from April 1st through September 30th.

"The Medicare Prescription Payment Plan is a voluntary program that allows you to spread your out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect plan premiums, which are billed and should be paid separately. By opting in to the program, you (or your authorized representative) are indicating you understand these Medicare Prescription Payment Plan terms and conditions. You are agreeing to be financially responsible for all amounts billed under the program. If you do not pay the amounts due under the program you will be terminated from the program, and will not be allowed to opt in again until the amounts owed are repaid in full. You can choose to opt out of the program at any time, however any outstanding amounts owed will continue to be billed and must be paid."