Florida complete care

Medicare Prescription Payment Plan Participation request form

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:

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. 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 form and the attached terms and conditions.
- Florida Complete Care 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, Florida Complete Care will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Florida Complete Care 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:

Florida Complete Care H9986
Medicare Prescription Payment Plan
P.O. Box 7
Pittsburgh, PA 15230

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

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) to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-833-FC2-PLAN (1-833-322-7526), 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."