

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 costs for drugs covered by your plan 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 Plans 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: - -					
Birth date: (MM/DD/YYYY): / /			Phone number: ()		
Permanent residence street address (don't enter a PO Box unless you're experiencing homelessness):					County (optional):
Apt #:	City:	State:	ZIP code:		
Mailing address, if different from your permanent address (PO Box allowed):					
Apt #:	City:	State:	ZIP code:		
Plan Selection 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. Judi Rx, on behalf of Blue Cross Group Medicare Advantage, will contact me if they need more information.
- I understand that signing this form means I have read and understand the form and the attached terms and conditions.
- **Blue Cross Group Medicare Advantage will let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I am not a participant in the Medicare Prescription Payment Plan.
- I understand that if I stay in the same health or drug plan, Blue Cross Group Medicare Advantage will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Blue Cross Group Medicare Advantage to opt out.

Signature:

Date:

If you are completing this form for someone else, complete the section below. Your signature certifies that you are authorized under State law to fill out this participation form and have documentation of this authority if Medicare asks for it.

NAME First:

Last:

MI

Address:

Apt #:

City:

State:

ZIP code:

Phone number: ()

Relationship to participant:

How to submit this form

For 2027 Participation: If you would like to participate in the Medicare Prescription Payment Plan effective January 1, 2027, you may choose one of the following enrollment methods:

1. Complete and submit the election request online through **MyPrime.com**.
2. Download, complete, and mail the election form to: Judi Rx, Attn: M3P Elections, 9450 SW Gemini Dr., Suite 87234, Beaverton, Oregon 97008-7105
3. Contact Customer Service for assistance with submitting an election request by phone at **1-833-894-3593**. Hours of Operation: 24 hours a day, 7 days a week; **711** (TTY).
4. Election requests can also be emailed to **M3P-Election@judi.com**.

If you have already submitted an election request for 2026 and remain eligible, your participation will automatically renew for 2027 unless you opt out.

Terms and Conditions for Participation in the Medicare Prescription Payment Plan

You attest and understand you must be a Medicare Part D member to participate in this program. 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). 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. 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. 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 judi.health/legal/privacy-policy for more information. 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.

HMO employer/union group plans are provided by HCSC Insurance Services Company (HISC)-H9706 and GHS Insurance Company (GHSIC)-H8133 and H8544. PPO employer/union group plans are provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)-H0107, H3822, and H8634, and HCSC Insurance Services (HISC)-H1666. HISC, HCSC, and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HISC, HCSC, and GHSIC are Medicare Advantage organizations with Medicare contracts. Enrollment in these plans depends on contract renewal.