iCare
INDEPENDENT CARE HEALTH PLAN

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is an **optional** 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 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 *i*Care at 800-777-4376 for more information.

Complete all fields unless marked optional

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

Medicare Number: C_____

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. *i*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.
- ***i*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.

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

You can

- **email this completed PDF to the *i*Care Pharmacy Department** at pharmserv@icarehealthplan.org

Or

- **mail your completed form (no need to include the Terms & Conditions pages) to:**

  *i*Care Health Plan

  Pharmacy Department

  1555 N RiverCenter Drive, Suite 206

  Milwaukee, WI 53212

Medicare Prescription Payment Plan Terms and Conditions

These terms and conditions ("Terms") govern the *i*Care Medicare Prescription Payment Plan (“the Program”), including, as available, participation in the Program. By participating in the Program, you agree to be bound by these Terms. *i*Care may change these terms based on guidelines from The Center for Medicare and Medicaid Services (“CMS”) and reserve the right to change these Terms, but will notify you of any changes, as required.

Participation

Participation in the Program is voluntary and may only extend to the end of each plan year. You will need to be an active *i*Care or member with a Part D prescription drug benefit plan. You will also need to have paid any past due balances on any participation in the Program from a previous year to *i*Care if your participation in the Program was previously terminated due to past due and unpaid balances.

If you are eligible to participate in the Program, you can opt-in and opt-out at any time within the plan year.

Billing

By participating in the Program, you agree to pay all covered Part D prescription drug costs incurred up to the maximum out of pocket amount of $2000 (could be less depending on your plan), as permitted by law, spread over the remaining months of the plan year. You will only be billed once a month for Part D drug prescriptions obtained during the prior month, spread over the remaining months of the year. You understand that your payments may increase every billing cycle with each additional Part D drug that you obtain. At all times while you participate in the Program, you will no longer pay at point-of-sale at the pharmacy (including mail order and specialty pharmacies) but will be billed for the covered part D prescriptions you obtained at the pharmacy by your plan, *i*Care. If you obtained Part D drugs from the pharmacy in December, your last bill for the plan year will be received in January of the following plan year.

Information on how to pay your balance will be provided on your monthly invoice.

Termination

Participation in the Program is not guaranteed. *i*Care will notify you if you miss a payment and will provide any past due balances on the next statement. Failure to pay the minimum balance due each month will result in a two-month grace period before you are terminated from the Program. If the minimum balance due and any past due payments are not paid within the two-month grace period, you will be terminated from the Program. Moving forward, you will pay for any additional prescriptions at point of sale at the pharmacy. *i*Care will notify you when your participation has been terminated and *i*Care will continue to bill you for any past due balances owed while you participated in the Program. *i*Care reserves all legal rights to collect unpaid balances from you. You may re-enter the Program with *i*Care once you pay any past due balances.

You will be removed from the Program if you switch Part D prescription drug plans during a current plan year, including if you switch plans within *i*Care. You will need to opt-in again to participate in the Program under

INDEPENDENT CARE HEALTH PLAN

Medicare Prescription Payment Plan Terms and Conditions

your new Part D plan. If you switch Part D prescription drug plans, you will owe any outstanding balances to *i*Care owed during your participation in the Program and will need to opt-in with your new prescription drug plan if you want to continue participating in the Program. Balances are not carried over to new prescription drug plans.

If you continue to pay your required premiums, you will not be removed from your *i*Care insurance plan if you are terminated from the Program.

Communications

By participating in the Program, you agree to receive telephonic and mail communications regarding your participation status, billing statements and overdue notifications. You may receive electronic communications which include payment reminders, payment confirmations, auto-pay confirmation and status if you have an email on file with *i*Care. You will have the right to unsubscribe from email notifications pertaining to this program. By unsubscribing you will no longer receive electronic payment reminders and account status and billing confirmations.

Disputes

If you disagree with our decisions, you have the right to ask *i*Care to review our decision. You must submit your dispute within 60 days after the incident or event that caused the grievance.

Grievance and Appeal Coordinator
Independent Care Health Plan
1555 N River Center Dr. Suite 206.
Milwaukee, WI 53212-3958
Attn: Appeals

Phone: 1-800-777-4376 x1076 or TTY users call: 1-800-947-3529
Fax: 1-414-918-7589
Email: advocate@icarehealthplan.org
Plan Hours: 8:30am-5:00pm Monday through Friday

Release of information:

By joining this Medicare Prescription Payment Plan (the Program), you acknowledge that *i*Care and vendors on its behalf may share your information with Medicare, who may use it to track your participation, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (See Privacy Act Statement below).

Privacy Act Statement:

INDEPENDENT CARE HEALTH PLAN

Medicare Prescription Payment Plan Terms and Conditions

The Centers for Medicare and Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange participation data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588**. Your response on this form is voluntary and will not affect enrollment in your *i*Care Prescription Drug Plan.**