AMERICAN HEALTH ADVANTAGE OF PENNSYLVANIA

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 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 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:

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. American Health Advantage of Pennsylvania 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.
- **American Health Advantage of Pennsylvania 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, American Health Advantage of Pennsylvania will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact American Health Advantage of Pennsylvania 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:
American Health Advantage of Pennsylvania
201 Jordan Road
Franklin, TN 37067
Fax: 1-855-417-9171 Email: enrollment@amhealthplans.com

You can also complete the participation request form online at Pa.AmHealthPlans.com, or call us at 615-905-5465 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-855-239-1022, 8:00 A.M. to 8:00 P.M., seven (7) days a week, October 1 through March 31; 8:00 A.M to 8:00 P.M., Monday through Friday, April 1 to September 30. TTY users can call 1-833-312-0046.