Retiree RxCare

50 Whitecap Drive
North Kingstown, RI 02852

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 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 (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:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Retiree RxCare will contact me if they need more information.

  I understand that signing this form means that I've read and understand the form.

- **Retiree RxCare 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
Please note: *Capital Rx is an approved vendor of Retiree RxCare (PDP).*

Submit your completed form to:

Capital Rx
Attn: M3P Elections
9450 SW Gemini Dr., Suite 87234
Beaverton, Oregon 97008-7105

You can also complete the participation request form online at **RetireeRxCarePDP.com,** call us at 855-693-3921 to submit your request via telephone or email to M3P-Election@cap-rx.com.

If you have questions or need help completing this form, call us at 855-693-3921. Representatives are available 24 hours a day, 7 days a week. TTY users can call 711.