COMMUNITY FIRST
HEALTH PLANS

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 does not 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

NAME First	**Last**	**MI** (Optional)

Medicare Number

Birth Date (MM/DD/YYYY)		**Phone Number**	

Permanent Residence Street Address (PO Box not allowed, unless experiencing homelessness)	**County** (Optional)

Apt #	**City**	**State**	**ZIP**

Mailing Address, if different from your permanent address (PO Box allowed)

Apt #	**City**	**State**	**ZIP**

Plan Year Selection

I want to participate in the Medicare Prescription Payment Plan for the:

☐ Current Plan Year ☐ Upcoming Plan Year

Important Note: If “Current Plan Year” is selected then your participation will begin immediately and will automatically renew for the upcoming plan year If you stay in the same health or drug plan.

Read and Sign Below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Community First Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP) will contact me if they need more information.
- I understand that signing this form means that I have read and understand the form and the attached terms and conditions.
- **Community First Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP) 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, Community First Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP) will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Community First

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 available if Medicare asks for it.

NAME First	**Last**	**MI**

Address			
Apt #	**City**	**State**	**ZIP**

Phone Number		**Relationship to Participant**	

How to Submit This Form

Submit your completed form to:

Community First Health Plans
Mailstop: 1002
MPPP Election Dept.
13900 N. Harvey Ave
Edmond, OK 73013

Fax: 440-557-6525
Email: ElectMPPP@RxPayments.com

You can also complete the participation request form online at Activate.RxPayments.com, or call us at 833-246-7612 to submit your request via telephone.

If you have questions or need help completing this form, call us at 833-246-7612, 8AM to 11PM EST 7 days a week from Dec 8 - Mar 31, 8AM to 11PM EST Mon – Fri from Apr 1 – Sept 30, 8AM to 1AM EST 7 days a week from Oct 1 - Dec 7. TTY users can call 711.

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Terms and Conditions for Participation in the Medicare Prescription Payment Plan

The Terms and Conditions listed below outline your rights, responsibilities, and the rules governing participation in the Medicare Prescription Payment Plan program. By agreeing to these Terms and Conditions-either online, over the phone or by signing and returning the election form-you confirm that you understand and accept the provisions of the program.

1. **No Fees or Interest**
   The Medicare Prescription Payment Plan does not charge any fees or interest, and no credit check is required to enroll in the Program.

2. **Notification to Pharmacy**
   Upon acceptance into the Medicare Prescription Payment Plan, we will inform your pharmacy that you are using this payment option.

3. **Applicability**
   This payment option applies only to Medicare Part D covered drugs processed after your election is confirmed.

4. **Cost Sharing**
   When you fill a prescription for an eligible Part D drug, you will pay zero dollars at the pharmacy. However, you will still be responsible to pay your cost share of the drug associated with your Medicare Part D benefit under your plan that can be paid through a monthly invoice.

5. **Monthly Invoices**
   Each month, you will receive an invoice detailing the out-of-pocket amount you owe, the due date, and information on how to make a payment. Monthly payments are required while you carry a balance, but you can pay the balance in full at any time.

6. **Calculation of Monthly Payments**
   The formula for calculating the minimum monthly payment (referred to as the “maximum monthly cap”) differs for the first month of participation versus the remaining months of the year. The maximum monthly cap calculations include specifics of a participant’s Part D drug costs (previously incurred costs and new out-of-pocket costs), as well as the number of months remaining in the plan year and the amount outstanding. As such, the amount can vary from person to person and month to month, and the total outstanding balance will be completely paid off by February 1st of the next calendar year.

7. **Missed Payments**
   If you miss a payment, you will receive a *Notice of Failure to Pay*. If you do not pay the outstanding amount due by the date listed in the reminder notice, you will be removed from the Medicare Prescription Payment Plan. However, you will still be required to pay the amount you owe and may not be able to re-enroll in the Medicare Prescription Payment Plan.

8. **Opting Out**
   You can leave the Medicare Prescription Payment Plan at any time by selecting the opt-out option through the website or by calling the phone number provided to you in the *Notice of Election Approval* letter, which will be sent to you by your plan after successful election into the program. After you opt out, you will continue to receive an invoice each month for the amount you owe until your balance is paid in full.

9. **Digital Communications and Notifications**
   If you provide an email, participation in this Program will automatically make you eligible for important emails containing information related to the Medicare Prescription Payment Plan.

10. **Disenrollment and New Plan Enrollment**
    If you are disenrolled from your plan for any reason and/or enroll in a new plan with drug coverage, your participation in the Medicare Prescription Payment Plan through your current plan will end. However, you will continue to receive an invoice each month for any outstanding amounts until your balance is paid in full. You remain responsible for the amount due under this Medicare Prescription Payment Plan. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.

11. **Address Updates**
    Any contact information or communication preferences you provide during election or directly through your Medicare Prescription Payment Plan online portal will only be used for your Medicare Prescription Payment Plan, and may not be communicated to your Medicare Part D plan. If you also need to make an address update for your Part D coverage then you will need to provide those directly to your Plan.

12. **Communications**
    By providing us with your contact information, you consent to our contacting you by any means you have provided regarding important information about your Medicare Prescription Payment Plan account. This consent allows us to use text messaging for informational and account service calls, but not for telemarketing or sales calls. This may also include contact from companies working on our behalf to service your account.

13. **Automatic Participation Renewal**
    Your participation in the Medicare Prescription Payment Plan will automatically renew for the following calendar year, unless you are enrolling in a new Medicare Part D plan or have opted out of the program prior to the beginning of the calendar year.

COMMUNITY FIRST
HEALTH PLANS

Non-Discrimination Notice

Community First Health Plans, Inc. (Community First) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Community First does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Community First provides free aids and services to people with disabilities to communicate effectively with our organization, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

Community First also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact Community First Member Services at the number on the back of your Member ID card or 1-800-434-2347. If you're deaf or hard of hearing, please call 711.

If you feel that Community First failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a complaint with Community First by phone, fax, or email at:

Community First Compliance Coordinator
Phone: 210-227-2347 | TTY: 711
Fax: 210-358-6014
Email: DL_CFHP_Regulatory@cfhp.com

If you need help filing a complaint, Community First is available to help you. If you wish to file a complaint regarding claims, eligibility, or authorization, please contact Community First Member Services at 1-800-434-2347.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

You may also file a complaint by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019 | TTY: 1-800-537-7697

Complaint forms are available at:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

Aviso sobre no discriminación

Community First Health Plans, Inc. (Community First) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual. Community First no excluye o trata de manera diferente a las personas debido a su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual.

Community First proporciona asistencia y servicios gratuitos a personas con discapacidades para comunicarse efectivamente con nuestra organización, como:

- Intérpretes calificados de lenguaje de señas
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, y otros formatos)

Community First también ofrece servicios gratuitos lingüísticos a personas cuyo idioma principal no es el inglés, como:

- Intérpretes calificados
- Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese al Departamento de Servicios para Miembros de Community First al 1-800-434-2347. TTY (para personas con problemas auditivos) al 711.

Si usted cree que Community First no proporcionó servicios lingüísticos gratuitos o se siente que fue discriminado/a de otra manera por motivos de su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género, u orientación sexual, usted puede comunicarse con Community First por teléfono, fax, o correo electrónico a:

Community First Compliance Coordinator
Teléfono: 210-227-2347 | Línea de TTY gratuita: 711
Fax: 210-358-6014
Correo electrónico: DL_CFHP_Regulatory@cfhp.com

Si usted necesita ayuda para presentar una queja, Community First está disponible para ayudarlo. Si usted desea presentar una queja sobre reclamos, elegibilidad o autorización, comuníquese con Servicios para Miembros de Community First llamando al 1-800-434-2347.

Usted también puede presentar una queja de derechos civiles ante el departamento de salud y servicios humanos de los Estados Unidos de manera electrónica a través del portal de quejas de derechos civiles, disponible en: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

También puede presentar una queja por correo o por teléfono al:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
Teléfono: 1-800-368-1019 | Línea de TTY gratuita: 1-800-537-7697

Los formularios de queja están disponibles en:
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

COMMUNITY FIRST HEALTH PLANS

Language Assistance

ENGLISH: ATTENTION: Free language assistance services are available to you. Call 1-800-434-2347 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, usted tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-434-2347 (TTY: 711).

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-434-2347 (TTY: 711).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務. 請致電 1-800-434-2347 (TTY: 711).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 (TTY: 711)번으로 전화해 주십시오.

ARABIC: رقم 1-800-434-2347 ق م ب ر ا ت ص ل باﻟ مجان . ل ك ف ت وت ى ة ا ل ل غ وع ةدع ا ل م اس خدمات ف إن ا ل ل غ ةذاك ر ت ت حدث ك تن م اذإ م لحوظة : 711 :واو ا ل ا ل مص هات

URDU: ک ا ل ۔ ہ ی ں د س ت ای ب م ی ں م فت خدمات ک ی ددم ک ی ز ب ا ن ک و آپ ت و ہ ی ں،ل ت ے ب و دو ا ر آپ ا گ ر ادر : خ رب 1-800-434-2347 (TTY: 711).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-434-2347 (TTY: 711).

FRENCH: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347 (ATS: 711).

HINDI: ध्यान द: यद आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 (TTY: 711) पर कॉल कर।

PERSIAN: توجه: اگر ب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان ب ارای شما تامس گیری. 1-800-434-2347 (TTY: 711) فراهم می باشد. اب

GERMAN: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-434-2347 (TTY: 711).

GUJARATI: ध्यान द: यद आप हदी बोलते है तो आपके लए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-800-434-2347 (TTY: 711) पर कॉल करे।

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-434-2347 (телетайп: 711).

JAPANESE:注意事項：日本語を話される場合，無料の言語支援をご利用いただけます. 1-800-434-2347 (TTY:711)まで、お電話にてご連絡ください.

LAOTIAN: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມ ໃຫ້ທ່ານ. ໂທຣ 1-800-434-2347 (TTY: 711).

COMMUNITY FIRST HEALTH PLANS

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

Español

ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-833-434-2347 (TTY: 711) o hable con su proveedor.

Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-434-2347 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

台語

注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-833-434-2347（TTY：711）或與您的提供者討論。

한국어

주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 자료 및 서비스도 무료로 이용하실 수 있습니다. 1-833-434-2347(TTY: 711)번으로 전화하시거나 담당 의료 서비스 제공자에게 문의하세요.

عربي

تنبيه: تتوفر لكم خدمات مساعدة لغوية مجانية. كما تتوفر أيضًا وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بتنسيقات سهلة الوصول. اتصلوا على الرقم 1-833-434-2347 (TTY: 711) أو تواصلوا مع مقدم الخدمة.

اردو

دھیان دیں: آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-833-434-2347

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-434-2347 (TTY: 711) o makipag-usap sa iyong provider.

Français
ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-434-2347 (TTY: 711) ou parlez à votre fournisseur.

हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-833-434-2347 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

فارسی
توجه: خدمات کمک زبانی رایگان برای شما در دسترس است. کمک‌های کمکی مناسب و خدمات ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-833-434-2347 (TTY: 711) تماس بگیرید یا با ارائه دهنده خدمات خود صحبت کنید.

Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-833-434-2347 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

ગુજરાતી
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-833-434-2347 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

РУССКИЙ
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-434-2347 (TTY: 711) или обратитесь к своему поставщику услуг.

日本語
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-833-434-2347（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

ລາວ
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-833-434-2347 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.