

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 Alamo Plan (HMO) 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 Alamo Plan (HMO) 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 Alamo Plan (HMO) will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Community First Medicare Advantage Alamo Plan (HMO) 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 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, Medicare Advantage Alamo Plan
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.

0106_2026

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. 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, Inc. is a HMO/HMO SNP with a Medicare and Texas State Medicaid Agency Contract. Enrollment in Community First Health Plans, Inc. depends on contract renewal. Community First markets under the names Community First Medicare Advantage Alamo Plan (HMO) and Community First Medicare Advantage Dual Eligible Special Needs Plan (HMO D-SNP). This information is not a complete description of benefits. Call 1-833-434-2347 or 711 for more information. You must Continue Plan 2026 to pay your Medicare Part B premium.

Non-Discrimination Notice

Community First Health Plans, Inc. and Community First Insurance Plans (Community First) comply with applicable federal civil rights laws and do 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 de no discriminación

Community First Health Plans, Inc. (Community First) y Community First Insurance Plans cumplen con las leyes federales de derechos civiles aplicables y no discriminan por motivos de raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género u orientación sexual. Community First no excluye ni 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 lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, como:

- Intérpretes calificados
- Información escrita en otros idiomas

Si usted necesita recibir estos servicios, comuníquese con Servicios para Miembros de Community First al número que aparece en el reverso de su tarjeta de Miembro o al 1-800-434-2347. Si tiene dificultades auditivas, por favor llame al 711. Si usted cree que Community First no le proporcionó servicios lingüísticos gratuitos o que fue discriminado/a de cualquier 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:

Coordinador de Cumplimiento Regulatorio de Community First

Teléfono: 210-227-2347 | TTY: 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 | TTY: 1-800-537-7697

Los formularios de queja están disponibles en:

<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-434-2347 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-434-2347 (TTY: 711) o hable con su proveedor.

پاملرنه: که چیرې تاسو په پښتو ژبه خبرې کوئ، په وړیا ډول د ژبې د مرستې خدمتونه ستاسو لپاره د لاسرسي وړ دي. د لاسرسي وړ ښو کي د معلوماتو د وړاندې کولو لپاره مناسبې مرستې او خدمتونه په وړیا ډول د لاسرسي وړ دي. له 1-800-434-2347 (TTY: 711) شمېرې سره اړیکه ونیسئ یا د خپلو خدمتونو له چمتو کونکي سره اړیکه ونیسئ.

تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 1-800-434-2347 (TTY: 711) أو تحدث إلى مزود الخدمة.

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 1-800-434-2347 (TTY : 711) ou parlez à votre fournisseur.

توجه: اگر به فارسی صحبت می کنید، خدمات رایگان کمک زبانی در دسترس شماست. کمک ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه دهنده خدمات خود صحبت کنید.

توجه: اگر شما دری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است. کمک ها و خدمات کمکی مناسب برای ارائه معلومات در فارمت های قابل دسترس نیز به صورت رایگان در دسترس است. با 1-800-434-2347 (TTY: 711) تماس بگیرید یا با ارائه کننده خود صحبت کنید.

注意: 如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-434-2347（文本电话：711）或咨询您的服务提供商。

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 1-800-434-2347 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ICYITONDERWA: Niba uvuga Ikinyarwanda, ufite serivisi z'ubufasha bw'ururimi ku buntu. Ibikoresho na serivisi byunganira bitangwa ku buntu kugira ngo amakuru atangwe mu buryo bworoshye kumva. Hamagara 1-800-434-2347 (TTY: 711) cyangwa uvugishe umuganga wawe.

DÍYAN DO: Zodi oñne Rohingya hotá hoo, toíle oñnolla maana zubani modot ókkol ase. Lootfaífade formeth ót maalamat dibolla munasef modotgorede caíjjo adde hédmot oñnolla taíbo. Kool goró 1-800-434-2347 (TTY: 711) ót yá oñnor dekbál doya loí hotá hoo.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-800-434-2347 (TTY: 711) au zungumza na mtoa huduma wako.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang 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 1-800-434-2347 (TTY: 711) o makipag-usap sa iyong provider.

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 1-800-434-2347 (TTY: 711) или обратитесь к своему поставщику услуг.

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। 1-800-434-2347 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

አስተውሉ: ትግርኛ ትዘረብ እንተ ኢንካ ብናጻ ናይ ቋንቋ ሓገዝ ኣገልግሎት ኪወሃበኩ ይኽእል እዩ። ብተወሳኺ 'ውን ብናጻ ሓበሬታ ንምሃብ ዚድሊ ሓገዚ ረድኤትን ኣገልግሎታትን ብናጻ ይርከብ። ናብ 1-800-434-2347 (TTY: 711) ደውሉ ወይ ምስ ወሃቢ ኣገልግሎትኩ ተዘራረብ።