CHAMPION HEALTH PLAN

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 Champion Health Pan at **1-800-885-8000 | TTY 711** for more information.

Complete all fields unless marked optional

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

Address:	**City:**	
County (optional):	**State:**	**ZIP code:**

Mailing address, if different from your permanent address (P.O. Box allowed):

Address:	**City:**	
County (optional):	**State:**	**ZIP code:**

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Champion Health Plan will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- Champion Health Plan 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:	**City:**	
County (optional):	**State:**	**ZIP code:**
Phone number: ( )	**Relationship to participant:**	

How to submit this form

Please mail this form to the address below or call the Champion Health Plan Member Services department at 1-800-885-8000 | TTY 711.

Submit your completed form to:

Champion Health Plan
5000 Airport Plaza Drive, Suite 100
Long Beach, California, 90815

You can also complete the participation request form online at championhmo.com/forms or call us at 1-800-885-8000 | TTY 711 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-800-885-8000 | TTY 711, Our team is available Monday – Friday, 8 am – 8 pm between April 1 and September 30, and 7 days a week, 8 am – 8 pm from October 1 to March 31.