BlueCross BlueShield Nebraska

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

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Blue Cross and Blue Shield of Nebraska MA will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Blue Cross and Blue Shield of Nebraska MA 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 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): _____
Phone Number: _____	Relationship to participant: _____

Submit your completed form to:

Blue Cross and Blue Shield of Nebraska
Mailstop: 1001
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 **888-488-9850** to submit your request via telephone.

If you have any questions or need help completing this form call us at **888-488-9850**, 8 a.m. to 9 p.m., Central time, seven days a week from Oct. 1 through March 31; 8 a.m to 9 p.m., Central time, Monday through Friday April 1 through Sept. 30. TTY users can call 711.

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