Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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 might help you manage your prescription 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 us for more information.

Complete all fields unless marked optional		
First Name:	Last Name:	Middle Initial (optional):
Enrollee ID (As displayed on your Blue Cross member ID card):		
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):			
City:	County (optional):	State:	Zip Code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Blue Cross Blue Shield of Michigan 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 Blue Shield of Michigan 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

Submit your completed form to:

Blue Cross Blue Shield of Michigan
Pharmacy Help Desk
Mail Code 512J
P.O. Box 441877
Detroit, MI 48244

You can also complete the participation request form online at **www.bcbsm.com/rxpaymentplan**, or call us using the number on the back of your ID card to submit your request via telephone.

If you have questions or need help completing this form, call us. TTY users can call 711.