

How to submit this form

You can also complete the participation request form online, or call us at the number on your ID card to submit your request via telephone.

Submit your completed form to:

Medicare Prescription Payment Plan
P.O. Box 7
Pittsburgh, PA 15230

If you have questions or need help completing this form, call us at the number on your ID card, TTY users can call 711, 24 hours a day, 7 days a week.

Medicare Prescription Payment Plan Terms and Conditions

The Medicare Prescription Payment Plan is a voluntary program that allows you to spread your out-of-pocket costs for covered Part D drugs across the remaining months of the plan year. The program does not affect your total prescription cost. Any applicable plan premiums are billed and should be paid separately from your Prescription Payment Plan billing statement. By opting in to the program, you (or your authorized representative) are indicating you understand these Medicare Prescription Payment Plan terms and conditions. You are agreeing to be financially responsible for all amounts billed under the program. If you do not pay the amounts due under the program you will be terminated from the program, and will not be allowed to opt in again until the amounts owed are repaid in full. You can choose to opt out of the program at any time, however any outstanding amounts owed will continue to be billed and must be paid.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.