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

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan, will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the attached fact sheet.
- **CalOptima Health OneCare Flex Plus 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:

CalOptima Health OneCare Customer Service
505 City Parkway West
Orange, CA 92868

Or fax this form to: 1-714-246-8711

You can also complete the participation request form online at **www.caloptima.org/OneCare**, or call us toll-free at **1-877-412-2734** (TTY **711**). to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week.

CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with Medicare and Medi-Cal contracts. Enrollment in CalOptima Health OneCare depends on contract renewal. CalOptima Health OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call CalOptima Health OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at **www.caloptima.org/OneCare**.