BlueCare Plus Tennessee

BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross 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 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. BlueCare Plus Tennessee 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 terms and conditions.
- **BlueCare Plus Tennessee 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:

ATTN: Medicare Prescription Payment Plan Election
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 5
Chattanooga, TN 37402-9923

You can also complete the participation request form online at bluecareplus.bcbst.com, or call us at **1-800-332-5762,** TTY **711** to submit your request via telephone.

If you have questions or need help completing this form, call us at Member Service: **1-800-332-5762**, From **Oct. 1 to March 31**, you can call us from 8 a.m. to 9 p.m. ET, seven days a week. From **April 1 to Sept. 30**, we're available from 8 a.m. to 9 p.m. ET, Monday through Friday. TTY users can call TTY **711**.