South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross Blue Shield Association.

Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by your plan by spreading them across the calendar year (January-December). **This payment option might 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:

I want to participate in the Medicare Prescription Payment Plan for the:
☐ Current Plan Year ☐ Upcoming Plan Year

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. BlueCross 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 included with this form.
- **BlueCross Medicare Advantage will 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.
- I understand that if I stay in the same health or drug plan, BlueCross Medicare Advantage will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact BlueCross Medicare Advantage to opt out

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: BlueCross Medicare Advantage

BlueCross Medicare Advantage
Attn: Medicare Prescription Payment Plan
P.O. Box 100191
Columbia, SC 29202-3191

Fax: 1-803-264-9581

You can also complete the participation request form online at www.SCBluesMedAdvantage.com, or call us at 1-833-730-1719 (TTY users should call 711).

If you have questions or need help completing this form, call us at 1-833-730-1719 (TTY users should call 711). Hours are 8 am to 8 pm, Eastern Time, Monday through Friday. Our automated phone system handles calls received after 8 pm and on Saturdays, Sundays, and holidays. From October 1 through March 31, we are available 8 am to 8 pm, Eastern Time, seven days a week. This call is free.