AmeriHealth Caritas
VIP Care

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: _ _ _ _ - _ _ _ - _ _ _ _	Member ID:

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. AmeriHealth Caritas VIP Care (HMO-SNP) 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 AmeriHealth Caritas VIP Care **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 the below address using the enclosed yellow envelope:

AmeriHealth Caritas VIP Care
P.O. Box 7139
London, KY 40742

Or fax your completed form to:

1-855-822-9400

You can also complete the participation request form online at **www.amerihealthcaritasvipcare.com/fl**, or call us at **1-833-535-3767** to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-833-535-3767**, 8 a.m. – 8 p.m., Monday through Friday, from April 1 to September 30. From October 1 to March 31, 8 a.m. – 8 p.m., seven days a week. TTY users can call **711.**

AmeriHealth Caritas VIP Care is an HMO-SNP plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

Medicare Prescription Payment Plan Billing Terms and Conditions

With the changing environment in health care, the Medicare Prescription Payment Plan is a new program created under the Inflation Reduction Act which begins January 1, 2025.

Thank you for choosing AmeriHealth Caritas VIP Care (HMO-SNP) as your health care provider. We are committed to the success of your treatment and care. Payment for services provided is a part of the Medicare Prescription Payment Plan. AmeriHealth Caritas VIP Care must provide enrollees the option to pay out-of-pocket prescription drug costs in the form of monthly payments over the course of the plan year, instead of all at once at the pharmacy.

Per the billing terms and conditions: Plan members are responsible for making the necessary payments toward covered Part D drug cost sharing you incur while in the Medicare Prescription Payment Plan program. Program participants will pay $0 to the pharmacy for covered Part D drugs, and AmeriHealth Caritas VIP Care will then bill program participants monthly for any cost sharing they incur while in the program. Pharmacies will be paid in full by AmeriHealth Caritas VIP Care in accordance with Part D prompt payment requirements.

AmeriHealth Caritas VIP Care is offering Plan members this opportunity to set up a payment plan for the prescriptions you will receive. This payment plan agreement authorizes AmeriHealth Caritas VIP Care to bill members based on the information on file as a method to collect payment for the services provided.

Each month, AmeriHealth Caritas VIP Care will send you a bill with the amount you owe for your prescriptions, when it is due, and information on how to make a payment. You will get a reminder from AmeriHealth Caritas VIP Care if you miss a payment and will be allowed a 60 day grace period to pay any past due payments.

If you do not pay your bill by the date listed in that reminder, you will be removed from the Medicare Prescription Payment Plan. You will have an opportunity to dispute the cancellation of your participation in the payment plan if there is a “good cause” reason for not paying your monthly bill. Call your plan if you think AmeriHealth Caritas VIP Care made a mistake about your Medicare Prescription Payment Plan bill or cancellation of your Medicare Prescription Payment Plan. You will have an opportunity to file a grievance pertaining to the cancellation of your participation. The grievance process can be found in your Evidence of Coverage.

You are required to pay the amount you owe, but you will not pay any interest or fees, even if your payment is late. If you are removed from the Medicare Prescription Payment Plan, you will still be enrolled in your Medicare health or drug plan.

Leaving won’t affect your Medicare drug coverage and other Medicare benefits. Keep in mind:

- If you still owe a balance, you’re required to pay the amount you owe, even though you are no longer participating in this payment option.
- You can choose to pay your balance all at once or be billed monthly.
- You will pay the pharmacy directly for new out-of-pocket drug costs after you leave the Medicare Prescription Payment Plan.

If your payment is not received by the due date on the invoice, you may receive notification of cancellation from the Medicare Prescription Payment Plan program.

For payments toward your balance, you are expected to:

- Make the payments as agreed upon without default.
- Make payments until the outstanding balance in your account is zero dollars ($0).

For your convenience, AmeriHealth Caritas VIP Care offers this payment plan with no finance or interest charges. If we receive the periodic payments set forth in this agreement, AmeriHealth Caritas VIP Care shall not pursue any additional collection actions on your account. If you still owe a balance that roles over to a new calendar year you will still be required to make that payment.

Signing the Medicare Prescription Payment Plan participation request form shall be considered binding of this Billing Terms and Conditions