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 out 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 health plan for more information.

Complete all fields unless marked optional			
First Name:	Last Name:		Middle Initial (optional):
Medicare Number:		ATRIO Health Plans Member ID:	
Birthdate: (MM/DD/YYYY)		Phone number:	
Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):			
Street:			
City:	County:	State:	ZIP code:
Mailing Address, if different from your permanent address (P.O. Box allowed)			
Street:			
City:	County:	State:	ZIP code:

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. ATRIO Health Plans 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 terms and conditions (attached).
- ATRIO Health Plans 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:
ATRIO Health Plans
2270 NW Aviation Drive, Suite 3
Roseburg, OR 97470

You can also complete the participation request form online at atriohp.com, or call us to submit your request via telephone. If you have questions or need help completing the form, call us at 1 877-672-8620 (TTY 711) daily from 8 a.m. to 8 p.m.

Terms and Conditions

- Monthly payments: The MPPP's monthly bill is based on the previous month's balance plus what would have been paid for prescriptions, divided by the number of months left in the year. Payments may change each month.
- Grace period: There is a 60-day grace period from the payment due date to termination from the program.
- Rejoining: The program can be rejoined after the past-due balance is paid.
- Out-of-pocket maximum: In 2025, the out-of-pocket maximum for covered prescription drugs is $2,000. Once this amount is reached, there is no cost sharing for Part D drugs for the rest of the year.
- Cost sharing: Cost sharing is capped at $35 for covered insulins and $0 for Part D recommended adult vaccines.
- Supplemental Part D benefits: These count towards individual out-of-pocket costs.
- There is no cost to enroll in the Medicare Prescription Payment Plan