1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY 711 | Fax: 715.221.9989

Medicare Prescription Payment Plan Participation Request

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 might help you manage your expenses, but it does not 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 _ _	Subscriber number
Birth date (mm/dd/yyyy) _____ /_____ /_____	Phone (_____) ___ ___ ___ – ___ ___ ___ ___

Permanent street address *(Do not enter a P.O. Box unless you are experiencing homelessness.)*

City	County *(optional)*	State	ZIP code

Mailing address *(only if different from your permanent street address - P.O. Box is allowed)*

Street address	City	State	ZIP code

Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Align powered by Sanford Health Plan (PPO) will contact me if they need more information.
- I understand that signing this form means that I have read and understand the form and the attached terms and conditions.
- **Align powered by Sanford Health Plan (PPO) 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 am not a participant in the Medicare Prescription Payment Plan.

Signature _____ Date (m/d/y) _____ /_____ /_____

If you are the authorized representative, complete the section below. Your signature certifies that you are authorized under state law to fill out this participation form and have documentation of this authority available if Medicare asks for it.

Name

Street address	City	State	ZIP code

Phone

Relationship to enrollee:
☐ Power of Attorney Durable/Financial ☐ Guardian of Estate/Conservator

How to submit this form

Submit your completed form to:

Align powered by
Sanford Health Plan (PPO)
Attn: Enrollment Services
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449
Fax: 715-221-9607

You can also call us at 1-888-278-6485 (TTY 711) to submit your request via telephone. Or, during the eligible plan year, you can complete your request using your secure member portal at align.sanfordhealthplan.com.

If you have questions or need help completing this form, call us at 1-888-278-6485 (TTY 711). We are open 7 days a week, 8 a.m. to 8 p.m., Oct. 1 – March 31; and Monday through Friday, 8 a.m. to 8 p.m., April 1 – Sept. 30.

Please retain a copy of this form for your records.

Terms and Conditions for Medicare Prescription Payment Plan

By electing to participate in the Medicare Prescription Payment Plan program, you agree to the following terms and conditions:

You are voluntarily electing to participate in the Medicare Prescription Payment Plan. Payments, which will not exceed the applicable monthly cap, are due monthly on the date shown on your invoice. You will be billed based on your designated payment method each month. Unless you specify otherwise, any payments made will be first applied towards your Part D plan premium. If you wish for your payment to instead be applied to your Medicare Prescription Payment Plan balance then you must specify as such.

Failure to pay your monthly billed amount may result in termination from the Medicare Prescription Payment Plan program. At any time you may choose to opt out of participation in the program by notifying Align powered by Sanford Health Plan (PPO) by mail, using your secure member portal at align.sanfordhealthplan.com or calling 1-888-278-6485 (TTY 711). You will be sent a notification confirming the termination within 10 calendar days of receipt of your request.

If you are terminated or voluntarily opt out of the program, then you will continue to be billed for any amounts owed under the program but in monthly amounts not to exceed the maximum monthly cap for the duration of the plan year after you have been terminated. You have the option, but are not required, to repay the full outstanding amount in a lump sum. If you owe an overdue balance, understand that you may be precluded in subsequent years from participating in the Medicare Prescription Payment Plan.

Upon leaving the Medicare Prescription Payment Plan program, you will resume paying for out-of-pocket cost sharing to the pharmacy for any covered Part D drugs subsequently dispensed up to the annual out-of-pocket threshold.

We may amend these terms and conditions periodically. Changes will be communicated via mail or email, based on your communication preference in your secure member portal at align.sanfordhealthplan.com.

All statements and answers given during election to participate in the Medicare Prescription Payment Plan are representations made by either a Part D enrollee or their representative. You agree that the answers provided are true and complete to the best of your knowledge.

Sanford Health Plan and Sanford Health Plan of Minnesota have HMO, PPO, I-SNP and D-SNP plans with a Medicare contract and contracts with state Medicaid programs. Enrollment in these plans depends on contract renewal. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1-877-509-4979 (TTY 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-509-4979 (TTY 711) o hable con su proveedor.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-509-4979 (TTY 711) an oder sprechen Sie mit Ihrem Provider.

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa 1-877-509-4979 (TTY 711) yookiin dhiyeessaa kee waliin haasa'aa.

If you require materials in large print, please call 1-877-509-4979 (TTY 711).