Hamaspik
MANAGED CARE

775 N. Main St.
Spring Valley, NY 10977
855-552-4642
www.hamaspik.com

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. Hamaspik Medicare Select will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Hamaspik Medicare Select 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:

Hamaspik Medicare Select
Attention: Medicare Prescription Payment Program
775 North Main Street
Spring Valley, NY 10977

Fax: 845-503-1900
Email: info@hamaspik.com

You can also or call us at 888-426-2774 to submit your request via telephone. (TTY users, call 711.)

If you have questions or need help completing this form, call us at 1-888-426-2774. (TTY users, call 711.) Staff are available 7 days a week, from 8:00 am to 8:00 pm, October 1st through March 31st, and Monday through Friday, 8:00 am to 8:00 pm, from April 1st, to September 30th.