SummaCare℠

Medicare Prescription Payment Plan

2025 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): ___

Your 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):

Street Address: _____

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. SummaCare 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.
- **SummaCare 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: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number:_____ Relationship to participant: _____

How to submit this form

Submit your completed form to:
SummaCare
P.O. Box 3620
Akron, Ohio 44309-3620

You can also complete the participation request form online at **summacare.com/plancentral**, or call us at **330.996.8885** or toll free at **800.996.6250** (TTY **711**) to submit your request via telephone.

If you have questions or need help completing this form, call us at **330.996.8885** or toll free at **800.996.6250** (TTY **711**). From October 1 through March 31, a representative will be available to take your call from 8:00 a.m. until 8:00 p.m., seven days a week. From April 1 through September 30, a representative will be available to take your call from 8:00 a.m. until 8:00 p.m., Monday through Friday. Outside these hours, you may leave us a message and a representative will return your call the next business day.

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If none of these statements applies to you or you're not sure, please contact SummaCare at **888.464.8440** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. until 8 p.m., seven days a week, from October 1 through March 31 and 8 a.m. until 8 p.m., Monday – Friday, from April 1 through September 30. SummaCare is an HMO and HMO-POS plan with a Medicare contract. Enrollment in SummaCare depends on contract renewal.
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SummaCare SM

Medicare Prescription Payment Plan

Terms and Conditions

- I understand that as a participant of this voluntary payment option, I will receive a monthly invoice for the amount I owe for prescriptions filled.
- I understand that payment will be due by the date indicated on the monthly invoice.
- I understand that I will be removed from the Medicare Prescription Payment Plan (involuntarily termed) if the payment for past due amounts is not received by the end of the grace period. When my participation ends, I will be responsible for paying the pharmacy directly for all new out-of-pocket drug costs.
- I understand that I can leave the Medicare Prescription Plan at any time (voluntarily term). If I still owe a balance, I am required to pay the amount I owe, even though I am no longer participating in this payment option.
- I understand that regardless of how my participations ends, I will continue to receive monthly invoices for prescriptions filled during my participation in the payment option until all amount owed is paid.
- I understand that if I am removed from the Medicare Prescription Payment Plan, I will NOT be able to use this payment option in the future until the amount owed has been paid.

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