



## Read and sign below:

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. Providence Medicare Advantage Plans will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form.
- **Providence Medicare Advantage 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.
- I understand that if I stay in the same health or drug plan, Providence Medicare Advantage Plans will automatically renew my participation in the Medicare Prescription Payment Plan at the beginning of each calendar year, unless I contact Providence Medicare Advantage Plans to opt out.

\_\_\_\_\_  
**Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Today's 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:

Capital Rx  
Attn: M3P Elections  
9450 SW Gemini Dr., Suite 87234  
Beaverton, Oregon 97008-7105

Election requests can also be emailed to: [M3P-Election@cap-rx.com](mailto:M3P-Election@cap-rx.com)

You can also complete the participation request on the Capital Rx Online Portal:

**[www.ProvidenceHealthAssurance.com/M3P](http://www.ProvidenceHealthAssurance.com/M3P)**, or call us at **1-855-742-2779 (TTY: 711)** 24 hours a day, 7 days a week, to submit your request via telephone.

If you have questions or need help completing this form, call us at **1-855-742-2779**, 24 hours a day, 7 days a week. TTY users can call 711.