



AIP Dual Advantage
 PO Box 3630 | Little Rock, AR 72202
 Phone: 866-488-5457
AIPCares.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 might 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. Tribute 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 attached terms and conditions.
- **Tribute 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:

**AIP Dual Advantage
PO Box 3630
Little Rock, AR 72202**

You can also complete the participation request form online at <https://myamethyst.com>, or call us at 1-866-488-5457 to submit your request via telephone.

If you have questions or need help completing this form, call us at 1-866-488-5457 (TTY 711), Monday - Friday, 8:00 a.m. to 8:00 p.m.



Medicare Prescription Payment Plan Terms and Conditions

Medicare Prescription Payment Plan applies to Part D Claims of members who opted-in to the program with the Health Plan beginning 1/1/2026. Members enrolled in the Health Plan may submit an opt-in request or opt-out request to the Health Plan's Medicare Prescription Payment Plan (M3P). Members will be notified of approval or denial of their request telephonically and via mailed letter. All member requests to opt-in to the program will be approved unless:

- The member was involuntarily opted-out of the program in our health plan in the prior year; or
- The member did not provide sufficient information to process the opt-in request.

Members may opt-out of the program at any time by calling Member Services, submitting the request electronically in the Health Plan's member portal, or by sending a written request via mail.

How does billing and payment work for M3P?

- The Pharmacy will be notified electronically of the Member's participation
- Drugs covered by Part D will be zero dollars at the pharmacy and billed by the plan
- Members opted-in to M3P will be billed monthly based on out-of-pocket amounts for the month and year
- Payments are due 30 day after the invoice is mailed
- Invoices will show what amount is due for the prior month as well as any outstanding amounts due from previous months
- Members can make M3P payments directly to the health plan via check or credit card and submit payments via mail or using the plans' website(s).
- Participants won't pay any interests or fees, even if their payment is late.

What happens if members do not pay M3P invoices?

- If an invoiced amount has not been paid 15 days after the due date, the 'Failure to pay' process will be initiated
- Initial 'Failure to pay' letter will be sent to member to remind them to pay
- If no payment is received 60 days after the first day of the month AFTER the payment is initially requested (Grace Period), the member will be involuntarily opted-out of the program
- An M3P Termination Letter will be sent within 3 business days of the end of the grace period.
- M3P Termination does not cause termination from the Health Plan
- Member may be re-instated in M3P if they pay the overdue billed amount
- Beneficiaries owing an overdue balance from the prior year will be precluded from opting-in to M3P for the current year

What will NOT change with opting-in to M3P?

- Members who opt-in or opt-out of the program still have the same copays, maximum out of pocket, and coverage rules
- M3P only applies to Part D covered drugs, so over-the-counter, excluded, or nonformulary drugs are not eligible for this levelized payment program
- Members with LIS will still have reduced or \$0 copays
- M3P does not lower the overall out-of-pocket costs for members, but rather spreads the same amount over a longer period, reducing monthly costs