Exhibit 2: Medicare Prescription Payment Plan Participation Request Form

Do you need assistance with managing your prescription costs? You can fill out this request form in your portal or you can mail in the form below:

Access the form online!

Fill out the form on your portal at MyMolina.com

- Log into the portal
- Go to "My Plan Resources"
- Click the "Helpful Links" tab
- Go to "Medicare Prescription Payment Plan"
- Fill out the form and submit

Mail in the form below!

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. Molina Medicare Choice Care (HMO) 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.
- **Molina Medicare Choice Care 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:

ATTN: Molina Healthcare Inc., Membership
Accounting Department
PO Box 22800
Long Beach, CA 90801-9945

You can also complete the participation request form online at MyMolina.com, or call us at (800) 665-0898, TTY: 711 to submit your request via telephone.

If you have questions or need help completing this form, call us at (800) 665-0898, October 1 – March 31, 8 a.m. to 8 p.m. local time, 7 days a week, or from April 1 – September 30, Monday – Friday, 8 a.m. to 8 p.m. local time. TTY users can call 711.

What you can expect after you submit:

You will receive one of the following within 10 days:

• An approval with a start date of your participation
• A request for more information; or
• A denial of the request

Visit MyMolina.com for more information. Call (800) 665-0898, TTY: 711 if you have any questions or need help.

https://www.molinahealthcare.com/members/common/en-US/multi-language-taglines.aspx