Clear Spring Health

Premium Payment Option Change Form (MAPD)

Please use one (1) form for each Member

Please complete the information below to tell us how you would like to pay your monthly premium. After you return this form, it may take up to 3 months for the change to take effect. This form does not apply to members that are in a $0 premium plan or don't have a late enrollment penalty.

Please complete, sign and return this form by email, fax or mail to:

Email achinfo@clearspringhealthcare.com

Fax (855) 231-8777

Mail PO Box 278530
Miramar, FL 33027

Do not send payments to the address above.

To make an online payment: https://login.clearspringhealthcare.net/

Member Name (first and last)

Member ID Number

Address

City

State

Zip Code

Home Phone Number

Other Phone Number

Please Note:

- We do not accept bank information or credit card payments over the phone.
- Members enrolling in an auto deduction premium payment option (SSA, RRB, EFT) will not receive a monthly invoice unless there is an outstanding balance.
- **It may take up to three months for your new payment option to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.** Any outstanding balance prior to the effective date of your new premium payment option must be paid with a check.

Select a payment option below and return before the end of the month.

○ **Social Security (SSA)/Railroad Retirement Board (RRB)**
In most cases if Social Security or RRB accepts your request for automatic deduction, the first deduction may include premiums due after you submit this form. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

○ **Deduction from my Bank Account (ACH)**
Please complete the information below. Your payment will be deducted between the 5th and 7th days of each month. We will only try to deduct your premiums once each month. If your bank rejects or returns your premium deduction, we will send you a letter with instructions on other ways to pay your premiums.

Bank Account Holder's Name (first and last)

Bank Name

Type of Account: Checking ○ Savings ○

Routing Number

Account Number

Please attach a blank, voided check. We will use it to validate the routing and account numbers you provided on this form. By signing below, you authorize Clear Spring Health to deduct your monthly premium from your bank account.

Bank Holder's Signature

Date

Please mail payments to:

Clear Spring Health
PO Box 660907
Dallas, TX 75266-0907

Please include your member ID number on the memo section of the check.

If you have questions about completing this form, please call:

Member Services: 1-877-364-4566 (TTY: 711)
Hours: M–F 8:00am–8:00pm (April 1–Sept. 30).
7 days a week 8:00am–8:00pm (Oct. 1–March 31). Voicemail available weekends and holidays.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 1-877-364-4566 (TTY:711).