**Instructions to Health Plans**

* [*If plans do not use the term “Member Services,” plans should replace it with the term the plan uses*.]
* [*Plans may use the term “doctor” or “health care provider” as appropriate within the document*.]
* [*Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation*.]

**<Entity Name and Logo>**

**<Plan Name> (HMO SNP) Enrollment Form**

[*Plans should include numbers for Enrollment, Member/Customer Services, and Prescription Drug. If these numbers are the same, plans can combine.*]

**<Plan name> Enrollment Telephone Numbers**<Local and/or 800 numbers>. TTY for the hearing impaired at <Local and/or 800 numbers>. <Days and hours of operation>. The call is free.

[*Optional:* **<Plan name> Member Services Telephone Numbers**<Local and/or 800 numbers>. TTY for the hearing impaired at <Local and/or 800 numbers>. <Days and hours of operation>. The call is free.]

**Medical and Prescription Drug questions:** <Local and/or 800 numbers>. TTY for the hearing impaired at <Local and/or 800 numbers>. <Days and hours of operation>.

**Return the completed form, pages <page number> to <page number>, to: <Plan>**

[*Include the following information somewhere on this form:*]

<Mailing Address>

<Fax Number>

[*Plans must include all applicable disclaimers as required federal regulations (42 CFR, Part 422, Subpart V, and Part 423, Subpart V) and State-specific Marketing Guidance*.]

[Plans must use instructions found in the Complaint and Language Block Guidance issued by the state.]

[*Plan may include American Indian Language insert on the front or the back if plan does not include in its language block/non-discrimination notice.*]

[Copies: <color/top copy>-<Plan Name> <color/bottom copy>-Member]

**<Plan Name> (HMO SNP) Enrollment Request Form**

To join <plan name>, you must have **Medicare Part A**, **Medicare Part B**, and **Medical Assistance (Medicaid)**, **and** be age 65 or over, **and** live in <plan>’s service area.

**Section 1. Tell us about yourself:**

| **1** | **Name: (first,** [*Optional***: middle,**] **last)** | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **2** | **Date of birth:** | | | **Sex:  Female  Male** | | |
| **(\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_)**  **M M D D Y Y Y Y** | | |  |  |  |
| **3** | **Phone number:** | | | [*Optional:* **Another phone number:**] | | |
| (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ | | | (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ | | |
| **4** | **Address where you live (P.O. Box is not allowed):** | | | | | |
| **City:** | | **State:** | **ZIP code:** | [*Optional:* **County:**] | |
| **5** | **Address where you get mail (if different from where you live):** | | | | | |
| **City:** | | **State:** | **ZIP code:** | [*Optional:* **County:**] | |
| **6** | **Do you live in a long-term care facility?  Yes  No** If Yes, fill in the information below: | | | | | |
| **Name of the facility:** | | | **Phone number:** | | |
|  | |  | ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_\_\_\_ | | |
| **7** | **Do you need an interpreter?  Yes  No** If Yes, check the language below: | | | | | |
| **** 01 Spanish | **** 02 Hmong | ** 0**3 Vietnamese | **** 04 Khmer (Cambodian) | **** 05 Lao | **** 06 Russian |
| **** 07 Somali | **** 08 ASL (American Sign Language) | **** 09 Amharic | **** 10 Arabic | **** 12 Oromo | ** 1**4 Burmese |
| **** 15 Cantonese | **** 16 French | **** 20 Korean | **** 21 Karen | **** 98 Other | |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | [*Optional: Plans number this item and renumber subsequent items if including.*] | | | | | |
| **Authorized Representative**: | | | **Authorized Representative phone number:**  ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ | | |
|  | [*Minnesota Plans leave this blank.* *State may insert additional required question(s) about other Medical Assistance (Medicaid) and/or demonstration-specific eligibility criteria*.] | | | | | |

**Section 2. Tell us more about yourself:**

**You are not required to answer questions or give any information in this section. It’s your choice to share this information with us.** We can’t deny you coverage if you don’t answer them.

| 8 | **Do you want us to send you information in a language other than English?** ** Yes  No**  [*Plans that meet the 5% language threshold, insert:*  If Yes, check the language below or write in your language if it isn’t included. *List the languages required in your service area with checkboxes and a space for Other.*  **** <required language*>*  **** <required language>  **** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]  [*Plans that do not meet the 5% language threshold for any language, insert:*  If Yes, write language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| 9 | **Do you want us to send you information in an accessible format?** ** Yes  No** If Yes, check format below. | | | | | |
| **** Braille | ****Large print | **** Audio | |  |  |
| Please contact <plan name> at <phone number> if you need information in an accessible format other than what’s listed above. Our office hours are <days and hours of operation>. TTY users can call <TTY number>. | | | | | |
| 10 | **Do you want to get information by email?  Yes  No** If Yes, provide your email address below.  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [*Plans may edit to include other means of electronic delivery. Plans may list the types or categories of information or materials available by email or other means of electronic delivery.*] | | | | | |
| 11 | **Do you work?** ** Yes  No** | | | **Does your spouse or domestic partner work?** ** Yes  No**  Does not apply | | |
| 12 | **Name of the primary care clinic/care system you are choosing:** | | | [*Optional:* **Primary care clinic/care system provider ID number found in the *Provider and Pharmacy Directory***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] | | |
| [*Optional:* Name of the <Dental/Chiropractic> clinic you are choosing:] | | | [*Optional:* <**Dental/Chiropractic**> **clinic ID number found in the *Provider and Pharmacy Directory***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] | | |
|  | [*Minnesota Plans leave this blank.* *State may insert additional optional question(s) about other Medical Assistance (Medicaid) and/or demonstration-specific eligibility criteria*.] | | | | | |

Section 3. Tell us about your Medicare and Medical Assistance (Medicaid) coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

|  |  |  |
| --- | --- | --- |
| **13** | **Medicare**  **Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **MHCP Member**  **Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 4. Tell us about your health coverage including your prescription drug coverage:**

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

|  |  |  |
| --- | --- | --- |
| **14** | **Do you have other health coverage?  Yes  No** If Yes, fill in the information below: | |
| **15** | **Name of your plan (and employer, if applicable):** | **Group number:** |
|  | **ID number:** |
| **16** | [*Plans include this item only if they do* ***not*** *include attestation questions on the enrollment form.*]  **Are you leaving employer or union coverage?  Yes  No** If Yes, what is the coverage end date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join <plan name>. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

[*Plans may include Section 5 and the attestation statements below on the enrollment form or on a separate document provided with the enrollment form. If plans include Section 5 and the attestation statements on the enrollment form, plans delete item 15 in Section 4 above.*]

**Section 5. Tell us about your enrollment eligibility.**

17. Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply**. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

 I am applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

 I am new to Medicare.

 I have both Medicare and Medical Assistance (Medicaid) (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven’t had a change.

 I recently had a change in my Medical Assistance (Medicaid) (newly got Medicaid or had a change in level of Medicaid assistance) on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I am leaving employer or union coverage on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

 I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare’s). I lost my drug coverage on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

 I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I recently was released from incarceration. I was released on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I recently obtained lawful presence status in the United States. I got this status on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you’re not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to find out if you’re eligible to enroll. We are open <days and hours of operation>.

[*Plans have the option to move this page to follow the Information and Acknowledgement Statements on the next page and edit location information as needed*.]

Please read the information on page <page number> and sign below.

When you sign this form, it means that you understand the information you read.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Applicant (Please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Today’s Date

If you are the authorized representative, **you must sign above** and provide the following information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Print) Relationship to Enrollee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Print) Telephone Number

When the form is completed, mail or fax [*insert:* it ***or*** pages <page number> to <page number>] to <plan name>. Our address and fax number are [*insert location where this information appears in the document, e.g.*:on the cover ***or***page <page number>, *etc.*].

<Office Use Only:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Authorized Sales Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_>

[Effective Date of Enrollment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Election Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIS Copay Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIS Copay Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

[*This box can be moved within the document but must be included.*]

**Information and Acknowledgement Statements**

|  |  |
| --- | --- |
| * My response to this form is voluntary. I understand that my enrollment in <plan name> may be affected if I don’t respond. * I must keep Medicare Part A and Part B and Medical Assistance (Medicaid) to stay in <plan name>. * By joining <plan name>, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize collection of this information (refer to the Privacy Act Statement below). * On the date <plan name> coverage begins, I must get my medical and prescription drug benefits from <plan name>. * Benefits and services <plan name> provides and contained in my *Member Handbook* are covered. Neither Medicare nor <plan name> will pay for benefits or services that are not covered. * I understand that <plan name> doesn’t usually cover people while they’re out of the country except under limited circumstances. * If I am now getting Elderly Waiver services through the county, I am aware that my case manager may be replaced by a different county case manager or a health plan care coordinator. | * If I move, I need to tell my <County Worker>. * I can choose to leave <plan name> at certain times of the year. I understand that I will be enrolled in <plan name> through the last day of the month. I understand that I will be automatically enrolled in the Minnesota Senior Care Plus (MSC+) plan, which will cover my Medical Assistance (Medicaid) benefits. If I ask in writing, I will be enrolled in my previous MSC+ plan. * If I get a medical spenddown while enrolled in <plan name> and do not pay it to the State, I will be disenrolled from <plan name>. * The information on this enrollment form is correct to the best of my knowledge. I understand that I will be disenrolled from <plan name> if I intentionally give false information on this form. * My signature (or my authorized representative’s signature) on this form means that I’ve read and understood this form. If an authorized representative signs, the person’s signature means that they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid). |

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.