IEHP Medicare DualChoice (HMO) Enrollment Form

IEHP Office Use Only.
Effective Date of Coverage: ___________

Please contact IEHP Medicare DualChoice (HMO) if you need information in another language or format (Braille).

1. Do you have End Stage Renal Disease (ESRD)? ❒ Yes ❒ No

If you answer **Yes** to this question you cannot enroll in IEHP's Medicare DualChoice (HMO) **unless** you do not need regular dialysis any more, or have had a successful kidney transplant (**Please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.)

2. Do you have zero Share-of Cost, Full Scope Medi-Cal? ❒ Yes ❒ No

If you answered **Yes**, what is your Medi-Cal #___________________________________

If you answered **No**, you cannot enroll in IEHP Medicare DualChoice (HMO).

3. Personal Information:

❒ Mr. ❒ Mrs. ❒ Ms.	First Name	MI	Last Name		
Date of Birth (MM/DD/YYYY)	❒ Male ❒ Female	Home Telephone ( )		Cell Telephone ( )	
Permanent Residence Street Address		Apt#	City	State	ZIP
Mailing Address (only if different from your Permanent Residence Address)		Apt#	City	State	ZIP
Email Address					
Emergency Contact		Telephone Number ( )		Relationship To You	

4. Please Provide Your Medicare Insurance Information:

- Please fill in these blanks so they match your red, white, and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

Note: You must have Medicare Part A and Part B to join IEHP Medicare DualChoice (HMO)

MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

YOUR NAME

MEDICARE Claim Number SEX

F / M

Effective Date

SAMPLE

5. Some individuals may have other health or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other health or prescription drug coverage in addition to IEHP Medicare DualChoice (HMO)? ❐Yes ❐No

If **yes**, please list your other coverage and your identification numbers (ID) for this coverage.

Name of other Coverage:	ID # for this coverage:	Group # for this coverage:

6. Are you a resident in a long-term care facility, such as a nursing home? ❐Yes ❐No

If **yes**, please provide the following information:

Name of Institution:	Address of Institution:	Phone of Institution:

7. Do you or your spouse work? ❐Yes ❐No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

❐Spanish ❐Large Print ❐Braille

Please contact IEHP Medicare DualChoice (HMO) at 1-877-273-4347 (TTY users should call 1-800-718-4347), if you need information in another language or format than what is listed above. Our office hours are 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

8. Please choose your primary care doctor (physician), clinic, or health center.

Doctor's ID Number:	Doctor's Name:

Please Read This Important Information

If you currently have health coverage from an employer or union, joining IEHP Medicare DualChoice (HMO) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join IEHP Medicare DualChoice (HMO). Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing and signing this enrollment application, I agree to the following:

IEHP Medicare DualChoice (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15- December 31 of every year), or under certain special circumstances.

Please Read and Sign Below (continued)

IEHP Medicare DualChoice (HMO) serves a specific service area. If I move out of the area that IEHP Medicare DualChoice (HMO) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of IEHP Medicare DualChoice (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from IEHP Medicare DualChoice (HMO) when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date IEHP Medicare DualChoice (HMO) coverage begins, I must get all of my health care from IEHP Medicare DualChoice (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by IEHP Medicare DualChoice (HMO) and other services contained in my IEHP Medicare DualChoice (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR IEHP MEDICARE DUALCHOICE (HMO) WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with IEHP Medicare DualChoice (HMO), he/she may be paid based on my enrollment in IEHP Medicare DualChoice (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that the IEHP Medicare DualChoice (HMO) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that IEHP Medicare DualChoice (HMO) will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by IEHP Medicare DualChoice (HMO) or by Medicare.

Your Signature: ______________________ Today's Date: ______________

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

Name: ______________________

Address: ______________________

Phone: ______________ Relationship To Enrollee: ______________

IEHP Office Use Only: **Plan ID # H5640, P001**

Name of staff member (if assisted in enrollment): ______________

Application is: ❒ APPROVED ❒ DENIED ❒ NOT ELIGIBLE

Applicant is enrolled in:

SNP Eligibility Verified	❒ Yes	❒ No
Medicare Part A	❒ Yes	❒ No
Medicare Part B	❒ Yes	❒ No
Zero Share-of-Cost, Full Scope Medi-Cal	❒ Yes	❒ No

Effective Date of Coverage: ______________

ICEP/IEP: __________ OEP: __________ AEP: __________ SEP (type): __________