MedStar Medicare Choice

If you have questions about this form, please call us at 855-242-4870. TTY users should call 855-250-5604.

OFFICE USE ONLY			
Plan ID#:	Effective Date:		
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:
Plan Representative/Broker:			
If you assisted with application, sign and date here:			
Application Mailed: _____ Faxed: _____			

Please contact MedStar Medicare Choice if you need information in another language or format (e.g., Braille).

I. TO ENROLL IN MEDSTAR MEDICARE CHOICE, PLEASE PROVIDE THE FOLLOWING INFORMATION

Name: First M.I. Last		Home phone number: ( )
Date of birth: mm/dd/yyyy	Sex: ☐ Male ☐ Female	Cell phone number *(if available)*: ( )

Email address *(optional)* and indicate permission to send information via email (e.g., newsletter): ☐ Yes ☐ No

Permanent residence address (Street, Apartment #): *P.O. Box is not allowed.*

City:	State:	Zip code:	County:

Mailing address (Street, Apartment #): *Only complete if different from permanent residence address.*

City:	State:	Zip code:	County:

2. PROVIDE YOUR MEDICARE INFORMATION

Please fill in the card to the right with the information from your red, white, and blue Medicare card. Otherwise, please attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Parts A and B to join our Plan. **We cannot consider your enrollment complete until you have given us this information.**

MEDICARE HEALTH INSURANCE

Sample Only

Name: _____

Medicare Claim Number: Sex: _____

__ __ __ - __ __ - __ __ __ __

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

3. PLEASE CHECK THE DISTRICT/STATE WHERE YOU LIVE AND WHICH PLAN YOU WANT TO ENROLL IN:

_____ DC _____ Maryland

You must continue to pay your Medicare Part B premium. The plan and premium listed below are for 2017 and may be different if you are enrolling for another year.

☐ MedStar Medicare Choice (HMO) - $17 monthly premium

For Medicare beneficiaries living with diabetes or chronic heart failure – chronic condition special needs plan (C-SNP):

☐ MedStar Medicare Choice Care Advantage (HMO SNP) - $17 monthly premium DC; $10 monthly premium Maryland

For Medicare beneficiaries who have Medicare Part A, Part B, and Medicaid coverage at the time of enrollment – dual eligible special needs plan (D-SNP):

☐ MedStar Medicare Choice Dual Advantage (HMO SNP) - $0 monthly premium

4. CHRONIC CONDITION INFORMATION

Complete this section only if applying for MedStar Medicare Choice Care Advantage. To be eligible for this plan, you must have one of these conditions: chronic heart failure (CHF) or diabetes. Please answer the questions below.

Has your doctor ever told you that you have diabetes (sugar)? ☐ Yes ☐ No

Has your doctor ever told you that you have chronic or congestive heart failure? ☐ Yes ☐ No

5. SELECT A PRIMARY CARE PHYSICIAN (PCP)

Name of selected PCP: _____ Practice Name _____
(First Name) (Last Name)

6. PAYING YOUR PLAN PREMIUM

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe), by check, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a bill each month.

I would like to pay my monthly late enrollment penalty, if applicable, by: ☐ Paper Check ☐ EFT ☐ Credit Card

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**
(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. If Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check should include all premiums due from your enrollment effective date up to the point withholding begins. If the first deduction does not include all premiums due from your enrollment effective date, we will send you a letter letting you know the amount you owe MedStar Medicare Choice for any premiums not deducted by Social Security or RRB. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Late Enrollment Penalty: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will include this amount on your monthly premium bill. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or RRB benefit check each month.

Part D IRMAA: If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium and/or late enrollment penalty. You can either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay MedStar Medicare Choice the Part D-IRMAA**

Low Income Subsidy: People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare only pays a portion of your plan premium, we will bill you for the amount that Medicare doesn't cover.

7. OTHER HEALTH INSURANCE INFORMATION

1) Do you or your spouse work full time? ☐ Yes ☐ No

2) Will you have other medical coverage in addition to MedStar Medicare Choice? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:	ID number:
Insurance company phone #:	Group number:
Subscriber name:	Subscriber date of birth:

3) Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
If "yes," please provide your Medicaid number: _____

Some individuals may have other **drug coverage**, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.

4) Will you have other prescription drug coverage in addition to MedStar Medicare Choice? ☐ Yes ☐ No
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Insurance company name:

ID number:	Group number:

8. PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

(a) Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
You may be able to enroll in this plan if you are currently enrolled in a MedStar Family Choice commercial product, or if you have had a successful kidney transplant, and/or you no longer need regular dialysis, please attach a note or records from your doctor. If this documentation is not attached, we may need to contact you to obtain additional information.

(b) Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes" please provide the following information *(this will NOT prevent you from enrolling in our plan):*

Name of institution: _____

Address of institution: _____ Phone number of institution: _____

9. INFORMATION TO DETERMINE YOUR ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. **Please read the following statements carefully and check all of the boxes to the left of the statements that apply to you.** By checking any of the 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 new to Medicare.	☐ I recently left a Program for All Inclusive Care for the Elderly program on (insert date) _____.
☐ I am either losing or leaving my employer or union group coverage on (insert date)_____.	☐ I get extra help paying for Medicare prescription drug coverage.
☐ 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 (insert date)_____.	☐ I belong to a pharmacy assistance program provided by my state.
☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.	☐ I recently left a pharmacy assistance program on (insert date) _____.
☐ I am moving into, live in, or recently moved out of a long-term care facility (e.g., nursing home). I moved/ will move into/out of the facility on (insert date) _____.	☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.	☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)_____.
☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the required special needs qualification. I was disenrolled from the SNP on (insert date) _____.
☐ I am disenrolling from a Part D plan to enroll in or maintain other creditable coverage.	☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
☐ I recently was released from incarceration. I was released on (insert date) _____.	☐ None of these statements apply to me.

Due to statements checked in this section, if it is determined that more than one effective date is applicable, my preferred effective date of enrollment is (insert date) _____.

10. ALTERNATIVE FORMAT OPTIONS

If you would prefer us to send you information in a language other than English or in another format, please check one of the boxes below or contact MedStar Medicare Choice at the phone number provided on page 1 of this application.

☐ Audio ☐ Large print ☐ Braille ☐ Language (please list) _____

Release of Information: By joining this Medicare Advantage health plan, I acknowledge that MedStar Medicare Choice will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that MedStar Medicare Choice will release my information, including my prescription drug event data, to Medicare, which may release it for research and other purposes that 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 from Medicare. **Your signature on this application means that you have reviewed and understand the plan benefits and Rights and Responsibilities listed at the BEGINNING of this form**.

I completed this application with assistance from a MedStar Medicare Choice representative.
☐ Face-to-face meeting ☐ Telephone call ☐ Completed by myself

Signature:_____ Today's Date:_____

This box is for completion of MedStar Medicare Choice Care Advantage (HMO SNP) Applicants Only
Please complete the information below that is required for enrollment in MedStar Medicare Choice Care Advantage

I _____ (enrollee name) authorize my treating doctor/provider to disclose the condition that I checked in this application to MedStar Medicare Choice for confirmation of eligibility. By signing I acknowledge that I have read and understand that I am giving my consent to share health information as described above.

Signature of enrollee/authorized representative:_____ Date:_____

This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon verification of ongoing eligibility.

Please provide the name and office phone number for your treating doctor/provider so MedStar Medicare Choice can confirm this information.

Provider Name:_____ Phone:_____

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

Name: _____ Relationship to enrollee: _____

Address: _____ Phone number: (_____)_____

Please return the WHITE COPY to MedStar Medicare Choice in the **postage-paid envelope** provided. **Please keep the Duplicate Copy for your records.**

MedStar Medicare Choice Rights and Responsibilities

By completing this enrollment application I agree to the following statements:

(a) I understand that if I currently have health coverage from an employer group or union, joining MedStar Medicare Choice could affect my current employer group or union health benefits. I could lose my employer group or union health coverage if I join MedStar Medicare Choice. I will read the communications my employer group or union sends me. If I have questions, I will visit their website, or contact the office listed in their communications. If there is no information on whom to contact, I will contact the benefits administrator.

(b) MedStar Medicare Choice (HMO), MedStar Medicare Choice Dual Advantage (HMO SNP) and MedStar Medicare Choice Care Advantage (HMO SNP) have contracts with Medicare. MedStar Medicare Choice Dual Advantage also has contracts with the Washington, D.C. Department of Health Care Finance and the Maryland Department of Health and Mental Hygiene (Medicaid) programs. Enrollment in MedStar Medicare Choice depends on contract renewal. MedStar Medicare Choice Dual Advantage is available to anyone who has both Medical Assistance from the State and Medicare. MedStar Medicare Choice Care Advantage is available to anyone with Medicare who has been diagnosed with Chronic Heart Failure and/or Diabetes. I will need to keep my Medicare Parts A and B coverage. I understand that I can be a member of only one Medicare Advantage plan at a time and that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. **I understand that when I am enrolled in the MedStar Medicare Choice HMO Plan, I will receive my Medicare prescription drug coverage through this plan. I do not need to enroll in a separate Prescription Drug Plan (PDP).**

(c) I understand it is my responsibility to inform MedStar Medicare Choice of any prescription drug coverage that I have or may get in the future through another plan. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

(d) I understand that 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: October 15 – December 7 of every year), or under certain special circumstances.

(e) MedStar Medicare Choice serves a specific service area. I understand that if I move permanently out of the service area that MedStar Medicare Choice serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

(f) I understand that, once I am a member of MedStar Medicare Choice, I have the right to appeal plan decisions about payments, services, or prescriptions if I disagree. I will read the Evidence of Coverage document from MedStar Medicare Choice when I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan.

(g) I understand that beginning on the date MedStar Medicare Choice coverage begins, I must get all of my health care from MedStar Medicare Choice, except for emergency or urgently needed services or out-of-area dialysis services.

(h) Services authorized by MedStar Medicare Choice and other services contained in my MedStar Medicare Choice Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. If a service requires an authorization and one is not obtained, **NEITHER MEDICARE NOR MEDSTAR MEDICARE CHOICE WILL PAY FOR THE SERVICES**.

(i) I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MedStar Medicare Choice, he or she may be paid based on my enrollment in this plan.

MedStar Medicare Choice

5233 King Ave
Suite 400
Baltimore, MD 21237-4001

2017_MSTR_APP_16MCID0128 (JMS)

MedStar Medicare Choice

For assistance completing this application, call MedStar Medicare Choice toll-free **855-242-4870**
TTY users call **855-250-5604**

Return the application in the postage-paid envelope or send to the following address:

MedStar Medicare Choice
P.O. Box 65
Pittsburgh, PA 15230-9922

Or you can fax the application to MedStar Medicare Choice at:
855-437-8762

Enrollment Application Instructions:

Please fill out each section of the enclosed application completely. **All information must be completed and the application signed, in order for your enrollment form to be processed.**

> **NOTE:** Medicare beneficiaries may enroll electronically in MedStar Medicare Choice through our website at MedStarMedicareChoice.com. You may also enroll through the CMS Online Enrollment Center at www.medicare.gov. For more information, contact our plan at the phone numbers below.

Section 1 – Name and Address Information: Complete your name and address information. The permanent residence address field must be your physical street address. Please do not list a P.O. box address in the permanent address field.

Section 2 – Medicare Information: Provide your name, Medicare Claim number, and effective dates (Parts A and B) exactly as they appear on your red, white, and blue Medicare identification card. You must have Medicare Part A and Part B to join a Medicare Advantage Plan. Your application cannot be finalized until MedStar Medicare Choice has your Medicare Claim number and effective dates of coverage.

Section 3 – Confirm Benefit Plan Option: Select whether you reside in Washington, D.C. or Maryland and then select what plan you want to enroll in.

Section 4 – Chronic Condition Information: This section is only to be completed by you if you have diabetes or chronic heart failure.

Section 5 – Primary Care Physician Selection: You will need to select a primary care physician (PCP) to coordinate your care. Please indicate the PCP name and PCP practice number, find on our website at MedStarMedicareChoice.com.

Section 6 - Premium Payment Option: Select the method you would like to use to pay your premium, if applicable. If you select Electronic Funds Transfer (EFT) or the credit card box on this application, you will receive additional information about electronic premium payment options with your MedStar Medicare Choice plan confirmation of enrollment letter.

Sections 7 and 8 – Other Health Insurance Information and Questions: If you have other health or prescription drug coverage, please provide this information. Also provide answers to the questions in Section 8 regarding end-stage renal disease and long-term care facility residence.

Section 9 – Information to Determine Your Enrollment Period: Read the statements and select the boxes that apply to you. By checking any of the boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period.

Section 10 – Alternative Format Options: If you require information in an alternative format, please select the format that best fits your needs. If you do not see a format you need, contact MedStar Medicare Choice Member Services. If you do not need an alternative format, you may skip this section.

Sign and Date the Application: After you have carefully read the MedStar Medicare Choice Rights and Responsibilities statements and completed the enrollment application, please sign and date the application where indicated.

For questions about this application, call MedStar Medicare Choice at 855-242-4870, from 8 a.m. to 8 p.m., seven days a week. TTY users should call 855-250-5604. Our hours of operation change twice a year. You can call us Oct 1 through Feb 14, seven days a week from 8 a.m. to 8 p.m. From Feb 15 through Sept 30, you can call us Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m. Please contact our plan if you need information in another language or format (e.g., Braille, large print, or audio).