MedStar Medicare Choice

Three easy ways to enroll

Phone

Contact one of our knowledgeable, licensed MedStar Medicare Choice representatives at **855-242-4870**. Our hours of operation change twice a year. You can call us October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 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. TTY users should call **855-250-5604**.

Online

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**.

Mail

Complete, sign, and date the following enrollment application and mail it to us.
Mail: **MedStar Medicare Choice**
P.O. Box 65
Pittsburgh, PA 15230

For questions or assistance with completing this application, call MedStar Medicare Choice at 855-242-4870. TTY users should call 855-250-5604.

Enrollment application instructions

Please fill out each section of the following application completely. **All information must be completed and you must sign the application for your enrollment form to be processed.**

Plan Option: Select one MedStar Medicare Choice benefit plan option.

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.

Provide Your Medicare Insurance Information: Provide your name, Medicare Number, and effective dates for Medicare Parts A and B exactly as they appear on your red, white, and blue Medicare ID 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 Number and effective dates of coverage.

Paying Your Plan Premium: Select the method you would like to use to pay your premium, if applicable.

Answer These Important Questions:

- Provide answers to the questions in this section regarding end-stage renal disease, other prescription drug coverage, long-term care facility residence, Medicaid, and your current employment.
- **You will also need to select a primary care physician (PCP).** If you are enrolling in an HMO plan, your PCP will help coordinate your in-network care. Please indicate the PCP name and practice number, which you can obtain from the MedStar Medicare Choice provider directory or on our website at **MedStarMedicareChoice.com**.
- 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, please contact MedStar Medicare Choice Member Services. If you do not need an alternative format, you may skip this section.

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.

Sign and Date the Application: After you have carefully read and completed the enrollment application, please sign and date the application where indicated.

MedStar Medicare Choice

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

To Enroll in MedStar Medicare Choice, please provide the following information:

Please check the District/State where you live and which plan you want to enroll in:

☐ DC ☐ Maryland

☐ MedStar Medicare Choice (HMO) - $36 DC / $27 Maryland monthly premium

For Medicare beneficiaries living with diabetes or chronic heart failure:

☐ MedStar Medicare Choice Care Advantage (HMO SNP) $27 monthly premium DC
$27 monthly premium Maryland

For Medicare beneficiaries who have Medicare Part A, Part B, and full Medicaid coverage:

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

LAST Name: FIRST Name: Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date (MM/DD/YYYY):	Home Phone Number: ( )
Sex: ☐ M ☐ F	Cell Phone Number: ( )
	Send me Text Messages: ☐ Yes ☐ No

Email: *(Optional)*

Permanent Residence Street Address *(P.O. Box is not allowed)*:

County:	City:	State:	ZIP Code:

Mailing Address *(only if different from your Permanent Residence Address)*:
Street Address: City: State: ZIP Code:

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

-OR-

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

Name (as it appears on your Medicare card):

_____

Medicare Number:_____

Is Entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) or credit card each month. You can pay your monthly plan premium, (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card. 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 are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay MedStar Medicare Choice the Part D-IRMAA (Income-Related Monthly Adjustment Amount).

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 co-insurance. 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 pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill

☐ Electronic Funds Transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank account number: _____

Bank routing number: __ __ __ __ __ __ __ __ __ Account type: ☐Checking ☐Saving

☐ Credit Card

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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Please read and answer these important questions:

1. Complete this question 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

2. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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

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

   _____ _____ _____

4. 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 & Phone Number of Institution (number and street): _____

5. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

6. Do you or your spouse work? ☐ Yes ☐ No

Please list the name of a Primary Care Physician (PCP) clinic or health center:

Practice Name: _____ Practice #: _____

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:

☐ Other Language (please list): _____

☐ Braille ☐ Audio ☐ Large Print

Please contact MedStar Medicare Choice at 855-242-4870 if you need information in another format or language than what is listed above. TTY users should call 855-250-5604. Our office hours are October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. and February 15 through September 30, Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. TTY users should call 855-250-5604.

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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 the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you may be disenrolled.

- ☐ I am new to Medicare
- ☐ I get extra help paying for Medicare prescription drug coverage
- ☐ I recently moved outside of the service area for the my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____
- ☐ I recently was released from incarceration. I was released on (insert date) _____
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____
- ☐ 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 PACE program on (insert date) _____
- ☐ I recently obtained lawful presence status in the United States 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 am leaving employer or union coverage on (insert date) _____
- ☐ I belong to a pharmacy assistance program provided by my state
- ☐ 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 special needs qualification required to be in the plan. I was disenrolled from the SNP on (insert date) _____

If none of these statements apply to you or you're not sure, please contact MedStar Medicare Choice at 855-242-4870 (TTY users should call 855-250-5604) to see if you are eligible to enroll. We are open October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. and February 15 through September 30, Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

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Please Read This Important Information

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

Please Read and Sign Below

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

MedStar Medicare Choice 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: October 15 – December 7 of every year), or under certain special circumstances.

MedStar Medicare Choice serves a specific service area. If I move out of the 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. Once I am a member of MedStar Medicare Choice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from MedStar Medicare Choice when I get it to know which rules I must follow 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 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. 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. Without authorization, **NEITHER MEDICARE NOR MEDSTAR MEDICARE CHOICE 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 MedStar Medicare Choice, he/she may be paid based on my enrollment in MedStar Medicare Choice.

Release of Information: By joining this Medicare 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, 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.

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Please Read and Sign Below	
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. 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:
If you are the authorized representative, you must sign above and provide the following information: Name: _____ Address: _____ Phone Number: ( ) _____ - _____ Relationship to Enrollee: _____	

Office Use Only			
Name of staff member/agent/broker (if assisted in enrollment):			
Ian ID#:		Effective Date of Coverage:	
ICEP/IEP:	AEP:	SEP (type):	Not Eligible:
If you assisted with this application, sign and date here:			
Agent/broker received by mail	Date received:	Agent/broker code:	
Application Mailed:	Faxed:		

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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 D.C. Department of Health Care Finance and the Maryland Department of Health (Medicaid) programs. Enrollment in MedStar Medicare Choice depends on contract renewal.

MedStar Medicare Choice Dual Advantage (HMO SNP) is available to anyone who has both Medical Assistance from the State and Medicare. MedStar Medicare Choice Care Advantage (HMO SNP) is available to anyone with Medicare who has been diagnosed with chronic heart failure and/or diabetes.

MedStar Medicare Choice and MedStar Medicare Choice Care Advantage members: you must continue to pay your Medicare Part B premium.

MedStar Medicare Choice Dual Advantage members: your Medicare Part B Premium is paid on your behalf by the state's Medical Assistance program.

Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

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