Provider Partners Health Plans

OMB No. 0938-1378
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# PROVIDER PARTNERS HEALTH PLANS ENROLLMENT REQUEST FORM

**Who can use this form?**
People with Medicare who want to join a Medicare Advantage Plan

**To join a plan, you must:**
- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:
- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

**When do I use this form?**
You can join a plan:
- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

**What do I need to complete this form?**
- Your Medicare Number (the number on your red, white and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

**Reminders:**
- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**What happens next?**
Send your completed and signed form to:

Provider Partners Health Plans
785 Elkridge Landing Rd
Suite 300
Linthicum Heights MD 21090

Once they process your request to join, they'll contact you.

**How do I get help with this form?**
Call Provider Partners Health Plans at 1-800-405-9681. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Provider Partners Health Plan al 1-800-405-9681 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

**Individuals experiencing homelessness**
- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

## Section 1 – All fields on this page are required (unless marked optional)

**Select the plan you want to join:**

- ☐ Provider Partners Illinois Advantage Plan HMO I-SNP (H3800-001) $22.80 per month
- ☐ Provider Partners Indiana Advantage Plan HMO I-SNP (H4444-001) $49.60 per month
- ☐ Provider Partners Maryland Advantage Plan HMO I-SNP (H8067-001) $46.30 per month
- ☐ Provider Partners Missouri Advantage Plan HMO I-SNP (H9191-001) $51.00 per month
- ☐ Provider Partners North Carolina Advantage Plan HMO I-SNP (H4439-001) $51.20 per month
- ☐ Provider Partners Pennsylvania Advantage Plan HMO I-SNP (H4093-001) $48.40 per month
- ☐ Provider Partners Texas Advantage Plan HMO I-SNP (H4054-001) $18.30 per month

| First Name: | Last Name: | Middle Initial (Optional): |
|---|---|---|
| | | |

| Date of Birth (MM/DD/YYYY) | Sex: | Phone number: |
|---|---|---|
| (_ _ /_ _/_ _ _ _) | ☐ Male ☐ Female | ( ) |

Permanent Residence street address (Don't enter a PO Box. *Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.*):

| City: | (Optional: County): | State: | Zip Code: |
|---|---|---|---|
| | | | |

Mailing address, if different from your permanent address (PO Box allowed):

| Street address: | City: | State: | Zip Code: |
|---|---|---|---|
| | | | |

### Your Medicare information:

**Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _

### Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Provider Partners Health Plans?

☐ Yes ☐ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| | | |

Are you a resident in a long-term care facility? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution:

Address & Phone Number of Institution (number and street):

## IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Provider Partners Health Plans.
- By joining this Medicare Advantage, I acknowledge that Provider Partners Health Plans 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 the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Provider Partners Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Provider Partners Health Plans. Benefits and services provided by Provider Partners Health Plans and contained in my Provider Partners Health Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Provider Partners Health Plans will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

| **Signature:** | **Today's Date:** |
|---|---|
| If you're the authorized representative, sign above and fill out these fields: | |
| Name: | Address: |
| Phone Number: | Relationship to enrollee: |

## Section 2 – All fields in this section are optional

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer.**

What's your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ I don't know
- ☐ **I choose not to answer.**

Select one if you want us to send you information in a language other than English. ☐ Spanish

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Provider Partners Health Plans at 1-800-405-9681 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

**Responses to these questions should not be interpreted as a request to provide materials and services in a Non English language. Should you wish for alternative language assistance please contact Member Services.**

What language do you feel most comfortable speaking with your clinician or health care provider?

☐ English ☐ Non-English ☐ Unknown ☐ Declined

In which language would you feel most comfortable reading medical or health care instructions?

☐ English ☐ Non-English ☐ Unknown ☐ Declined

What is the primary language spoken at home?

☐ English ☐ Non-English ☐ Unknown ☐ Declined

## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** DON'T pay Provider Partners Health Plans the Part D-IRMAA.

**Please select a premium payment option:**

☐ Get a bill each month

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

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

☐ 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 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 accepts your request for automatic deduction, the first deduction from your 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.)

## For individuals helping enrollee with completing this form only

**Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.**

Name: _____ Relationship to enrollee: _____

Signature: _____ National Producer Number (Agents/Brokers only):

_____

**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 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.

**Office Use Only:**

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID # _____ Date application received: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (Type): _____ Not Eligible: _____

If the form was completed at a Marketing event, put event ID here: _____