

Presbyterian MediCare PPO Individual Enrollment *Request* Form

To enroll in Presbyterian MediCare PPO, Please Provide the Following Information:

Please check which plan you want to enroll in:

- | | |
|--|-----------------|
| _____ Presbyterian MediCare PPO Plan 1 (Medical Benefits Only) | \$49 per month |
| _____ Presbyterian MediCare PPO Plan 2 with Rx | \$84 per month |
| _____ Presbyterian MediCare PPO Plan 3 with Rx | \$105 per month |

LAST name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
------------	-------------	----------------	---

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: <i>(providing this information is optional)</i>	Home Phone Number: ()
---	---	--	---------------------------

Permanent Residence Street Address:

City:	State:	ZIP Code:
-------	--------	-----------

Mailing Address (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:
-----------------	-------	--------	-----------

Emergency contact: _____

Phone Number: _____ **Relationship to You:** _____

E-mail Address: _____

Please Provide Your Medicare Insurance Information:

Please take out your Medicare Card to complete this section.

- 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.

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



Name: _____

Medicare Claim Number _____ Sex _____

Is Entitled To: _____ Effective Date _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium:

You can pay your monthly plan premium by mail. We will send you a bill each month. You may also pay by Electronic Funds Transfer (EFT), charge to your credit card each month (Presbyterian MediCare PPO accepts MasterCard and VISA), or you may pay your premium annually. You can also choose to pay your premium by automatic deduction from your Social Security check each month.

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 does not cover.

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

Please select a premium payment option:

- Receive a bill monthly.
- 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 Savings
- Credit Card. Please provide the following information:
Type of Card (MasterCard or VISA): _____
Name of Account Holder as it appears on the card: _____
Account Number: _____
Expiration Date: ____/____ (MM/YYYY)
- Automatic Deduction from your *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

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

If you answered "yes" to this question and 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 that you do not need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other 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 Presbyterian MediCare PPO? Yes No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID Number for this coverage: _____ Group Number for this coverage: _____

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

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

If yes, please provide your Medicaid number: _____

5. 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 _____ Audio tape

If you need information in another format or language than what is listed above, please contact Presbyterian MediCare PPO at (505) 923-6060 or 1-800-797-5343, Monday through Sunday from 8 a.m. to 8 p.m. TTY users should call 1-888-625-8818.



Please Read This Important Information

If you currently have health coverage from an employer or union, joining Presbyterian MediCare PPO could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Presbyterian MediCare PPO may change how your current coverage works. 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 is no 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 this enrollment application, I agree to the following:

Presbyterian MediCare PPO is a Medicare Advantage plan and *has a contract with the Federal government*. I will need to keep my Parts A and B. I can only be in 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. I understand that if I do not 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. 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 through December 31 of every year), or under certain special circumstances.*

Presbyterian MediCare PPO serves a specific service area. If I move out of the area that Presbyterian MediCare PPO 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 Presbyterian MediCare PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Member Handbook/ Evidence of Coverage* document from Presbyterian MediCare PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Presbyterian MediCare PPO coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Presbyterian MediCare PPO provides reimbursement for all covered benefits, even if received out-of-network. Services authorized by Presbyterian MediCare PPO and other services contained in my Presbyterian MediCare PPO *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PRESBYTERIAN MEDICARE PPO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Presbyterian MediCare PPO, he/she may be compensated based on my enrollment in Presbyterian MediCare PPO.

Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Presbyterian MediCare PPO 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 behalf of the individual under the laws of the State where the individual resides) 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 Presbyterian MediCare PPO 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 Number: (_____) _____ - _____

Relationship to Enrollee _____

Office Use Only:

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

Plan ID Number: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____