PriorityMedicare D-SNP enrollment form

PriorityHealth

Thank you for choosing a Medicare D-SNP plan from Priority Health. Please read the following before completing your application.

This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and full Medicaid assistance from the State. If your enrollment is not accepted, we will notify you immediately.

You are eligible to join the **Priority**Medicare D-SNP℠ (HMO) plan if:
(1) You are enrolled in Medicare Parts A and B.
(2) You are eligible for full Medicaid benefits.
(3) You reside within the Priority Health Medicare service area.
(4) You are a United States citizen or lawfully present in the United States; and
(5) You are 21 years of age or older.

Follow these helpful tips to avoid delays in processing your enrollment. Carefully read, sign and date all necessary portions of the application.

- ☐ Choose an enrollment eligibility selection that applies to you on the first page.
- ☐ Complete the Medicare Insurance information section using your Medicare red, white and blue card.
- ☐ Provide your Medicaid insurance information on so we can verify your Medicaid eligibility. Your Medicaid number is located on your MIHealth Card.
- ☐ Your completed application must be received on or before the last day of the month in order to be effective the first day of the following month.

You can enroll online or by using this paper form. To enroll online visit *priorityhealth.com/dsnp*, the Provider/Pharmacy Directory and Formulary are also available here. You can also call one of our Medicare experts at 888.379.0019 help you enroll.

To enroll using this paper form, mail the completed form using the enclosed postage-paid envelope. If you do not have a postage-paid envelope you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525.

If you have any questions or you would prefer that we send you information in another format, such as large print or Braille call our Medicare experts toll-free at 888.356.1360 from 8 a.m.–8 p.m., seven days a week (TTY users should call 711).

Medicare enrollment request form

Attestation of eligibility for an 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 for the statement that applies to you.
By checking any of the following 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.

Medicare enrollment request form

Choose one of the following:

- ☐ I am new to Medicare *(example: recently enrolled in Medicare Parts A and B).*
- ☐ 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 am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).
- ☐ I am leaving employer or union coverage on (insert date) ____/____/____ *(example: retiring and losing coverage through an employer).*
  Employer or union name: _____
  Group number: _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a one-time change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I currently have Medicare Parts A and B due to disability and am turning 65 years of age.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____/____/____.
- ☐ I recently had a change in my Medicaid coverage on (insert date) ____/____/____
  (example: newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).
- ☐ I recently had a change in my extra help paying for Medicare prescription drug coverage on (insert date) ____/____/____ *(example: newly got extra help, had a change in the level of extra help, or lost extra help).*
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get extra help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage 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) ____/____/____.
- ☐ My plan is ending its contract with Medicare.
- ☐ 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 that plan. I was disenrolled from the SNP on (insert date) ____/____/____.
- ☐ I recently was released from incarceration. I was released on (insert date) ____/____/____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____/____/____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ____/____/____.
- ☐ I recently left a PACE program on (insert date) ____/____/____.
- ☐ I belong to a pharmacy assistance program provided by any state.
- ☐ I'm new to Medicare, and was notified about getting Medicare after my Part A and/or Part B coverage started. I was notified on (insert date) ____/____/____
- ☐ I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
- ☐ I'm in a plan that's had a star rating of less than three stars for the last 3 years. I want to join a plan with a star rating of three stars or higher.
- ☐ I was previously enrolled in a Cost Plan that did not renew their contract with CMS.
- ☐ I was enrolled in a D-SNP plan that I am no longer eligible for.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact Priority Health Medicare to see if you are eligible to enroll. Call toll-free 888.356.1360 (TTY users should call 711), 8 a.m. – 8 p.m., seven days a week.

To enroll in the PriorityMedicare D-SNP plan, please provide the following information:

Please choose the name of a doctor (primary care provider [PCP]), otherwise one will be assigned to you (if applicable). You may change your PCP at any time.
First name of doctor: _____ Last name of doctor: _____

Last name	First name	M.I. *(optional)*

Birth date	Sex	Race (optional)
___/___/____ MM DD YYYY	☐ M ☐ F	☐ Hispanic/Latino ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Additional questions
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, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ I choose not to answer.

Phone number that we may use to contact you:	Alternate number that we may use to contact you (optional):
( ) ☐ Landline (home phone) ☐ Mobile phone	( ) ☐ Landline (home phone) ☐ Mobile phone

Permanent residence street address (P.O. Box is not allowed)

City	County	State	ZIP code

Mailing street address (only if different from your permanent residence address)

City	County	State	ZIP code

Email address	Please include your email if you would like to opt-in to receiving plan documents and other health and plan information by email. You can unsubscribe at any time.

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.

Agent use only

Referring agent: _____ Referring agent #: _____ Agent received application on: _____
Field Market Organization (FMO) name (if applicable): _____ FMO received application on (if applicable): _____

Scope of appointment completed:
☐ Yes. Date: _____ ☐ No. Reason: _____

Paying your plan premium

The PriorityMedicare D-SNP plan does not have a premium, however, if we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we will send you a bill in the mail.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-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. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare or RRB. Do NOT pay Priority Health the Part D-IRMAA.

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 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at *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.

Please read and answer these important questions:

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

   You must provide this important information to enroll in the Priority Medicare **D-SNP plan.**

2. Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format (optional):

☐ Spanish

☐ Braille ☐ Large print

Please contact Priority Health at 888.356.1360 (TTY 711), from 8 a.m. to 8 p.m., seven days a week if you need information in an accessible format other than what is listed above.

3. 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 Priority Health Medicare? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage: _____ Group # for this coverage: _____

4. Do you or your spouse work? *(optional)* ☐ Yes ☐ No

If you would prefer that we send you information in another format, contact us toll-free at 888.356.1360 from 8 a.m. – 8 p.m., seven days a week. TTY users should call 711.

STOP! Please read this important information

If you currently have health coverage from an employer or union, joining Priority Health Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Priority Health Medicare. 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 this enrollment application, I agree to the following:** Priority Health Medicare plans are Medicare Advantage plans and have 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 Advantage 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 calendar 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: Oct. 15 - Dec. 7 of every year) or under certain special circumstances.
- Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare 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 Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage Document from Priority Health Medicare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that Priority Health Medicare provides coverage for me in the United States and around the world for emergency and urgent care.
- Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.
- I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Priority Health Medicare, he/she may be paid based on my enrollment in Priority Health Medicare.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that Priority Health Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Priority Health Medicare 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 from Medicare.

Signature: _____

Today's date: _____/_____/_____

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

Name: _____

Street address:_____

City: _____ State:_____ Zip code:_____

Phone number: ( ) _____

Relationship to enrollee (e.g. Power of Attorney or legal guardian) _____

We require documentation to verify legal guardianship agreements. Please scan and email or mail legal documents to: Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525 or *PH-DSNPEnrollment@priorityhealth.com.*
You may also create a member account and send the documentation via secure message.

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 and 1860D-1 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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of Information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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Priority Health has a D-SNP (HMO) plan with a Medicare contract and a contract with the State Medicaid program. Enrollment in Priority Medicare D-SNP (HMO) depends on contract renewal. H8379_100010702301_C CMS-approved 07292022