OptimaHealth

Optima Community Complete

2019 Optima Community Complete (HMO SNP) Enrollment Request Form

Contact Optima Community Complete (HMO SNP) at 1-866-983-1150 (TTY Call 711) if you need information in another format or language. Our office hours are 8 a.m. – 8 p.m., 7 days a week, Oct. 1 – Dec. 7; 8 a.m. – 5 p.m., Mon. – Fri., Dec. 8 – Sept. 30.

This plan requires individuals to have both Medicare and Medicaid coverage.

To enroll in Optima Community Complete (HMO SNP), please provide the following information:

Effective Date Requested:			
☐ Mr. ☐ Mrs. ☐ Ms.	FIRST Name:	Middle Initial:	LAST Name:
Birth Date: (MM/DD/YYYY)	Sex: ☐ M ☐ F	Home Phone Number: ( ) Alternate Phone Number: ( )	
Email Address: _____ ☐ I give Optima Health permission to send my plan materials and member communications, excluding EOBs, by email.			
Permanent Residence Street Address: (**P.O. Box is not allowed**)			Apt. #
City or County:	State: VA	ZIP Code:	
Mailing Address - Street Address/P.O. Box: (**only if different from your Permanent Residence Address**):			Apt. #
City or County:	State:	ZIP Code:	
Emergency Contact Name:	Relationship to you:		
Emergency Contact Phone Number:			
Please choose the name of a Primary Care Physician (PCP):			

White copy: Optima Health • Pink copy: Applicant

H2563_SEN_SNPIEF2019_B_M

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.

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

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Paying Your Plan Premium and/or Late Enrollment Penalty (LEP):

If we determine that you owe a Late Enrollment Penalty (LEP), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT) each month, or by automatic deduction from your monthly Social Security Benefit or Railroad Retirement Board (RRB) benefit check. If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part 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 benefit check or be billed directly by Medicare or the RRB. DO NOT pay Optima Community Complete (HMO SNP).

Please provide any non-Medicare pharmacy plan information for drug coverage you have had since becoming eligible for Medicare Part D benefits to determine whether you may be charged a LEP.

Plan Name	Policy Number	Beginning/Ending Date
_____	_____	_____

Please select a Premium Payment or LEP option:

If you have a premium payment or LEP and do not select a payment option, you will receive a bill each month.

☐ Receive a monthly bill

☐ Automatic deduction from your monthly Social Security or RRB benefit check. The Social Security /RRB deduction may take several months to begin. Please be aware, if the withholding does not start at time of enrollment, you will be responsible for payment until withholding begins. You will receive a bill.

I get monthly benefits from: ☐ Social Security ☐ RRB

Please Read and Answer These Important Questions:

1. Do you have End Stage Renal Disease? ☐ Yes ☐ No

If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

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

3. Do you currently have any other medical coverage, including other **private insurance, VA benefits, Medicaid, TRICARE,** or **Federal Employee Health Benefits** coverage? ☐ 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:	Ending Coverage Date:
_____	_____	_____	_____

Will you have any other **prescription drug coverage** in addition to Optima Community Complete (HMO SNP)? ☐ 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:	Ending Coverage Date:
_____	_____	_____	_____

Eligibility Attestation for Enrollment:

This certifies that, to the best of your knowledge, you are eligible to enroll at this time. You may be disenrolled if this information is incorrect. Please review and check any of the following statement(s) that apply:

☐ Have Medicaid or the state helps pay for your Medicare. Medicaid Number: _____

☐ Eligible for Annual Enrollment Period

☐ Newly eligible to Medicare Part A and/or Part B: _____ (date)

☐ Leaving your employer or union coverage: _____ (date)

☐ Recently moved and this plan is now an option: _____ (date)

☐ Recently left a PACE program: _____ (date)

☐ Belong to a State Pharmacy Assistance Program

☐ Recently involuntarily lost creditable/prescription coverage: _____ (date)

☐ Receive Extra Help paying for your Medicare prescription drugs: _____ (date)

☐ Moving in, live in, or recently moved out of a Long-Term Care Facility (nursing home): _____ (date)

Name of Institution: _____ Phone Number: _____

Address of Institution (number and street): _____

☐ Other (please indicate reason): _____

If these do not apply, please contact Optima Community Complete (HMO SNP) 1-866-983-1150 (TTY call 711), to see if you are eligible to enroll, 8 a.m. – 8 p.m., 7 days a week, Oct. 1 – Dec. 7; 8 a.m. – 5 p.m., Mon. – Fri., Dec. 8 – Sept. 30

Please Read the Important Information on Page 5 and Sign Below.

If you currently have health coverage from an employer or union, joining Optima Community Complete (HMO SNP) could affect your ability to keep your employer or union health coverage. **You could lose your employer or union health coverage if you join Optima Community Complete (HMO SNP).** 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.

I understand that my signature (or the signature of the legal representative 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, including the agreement on page 5. 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 Optima Community Complete (HMO SNP) or by Medicare.

Signature:	**Today's Date:**

Legal Representative: Sign above, provide information below.

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ **Relationship to Enrollee:** _____

Agent Use Only: Agent Name **(please print):** _____ Agent NPN#: _____

Please Read Below

Optima Community Complete (HMO SNP) is a Coordinated Care Plan with a Medicare contract and a contract with the Virginia Medicaid Program. Enrollment in Optima Community Complete (HMO SNP) depends on contract renewal.

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

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. 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 (For example: October 15 - December 7 of every year), or under certain special circumstances.

You must continue to pay or have the State pay for your Medicare Part B premium.

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

Optima Community Complete (HMO SNP) serves a specific service area. If I move out of the area that Optima Community Complete (HMO SNP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that people with Medicare are not usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Once I am a member of Optima Community Complete (HMO SNP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Optima Community Complete (HMO SNP) when I receive it to know which rules I must follow to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Optima Community Complete (HMO SNP) coverage begins, I must get all of my Medicare covered services from Optima Community Complete (HMO SNP), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Optima Community Complete (HMO SNP) and other services contained in my Optima Community Complete (HMO SNP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR OPTIMA COMMUNITY COMPLETE (HMO SNP) 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 Optima Community Complete (HMO SNP), he/she may be paid based on my enrollment in Optima Community Complete (HMO SNP).

Release of Information: By joining this Medicare health plan, I acknowledge that Optima Community Complete (HMO SNP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Optima Community Complete (HMO SNP) 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.

Office Use Only:

Plan ID #: _____ **Effective Date of Coverage:** _____

☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____