Optima Health

**Southside**

# 2019 Optima Medicare HMO Enrollment Request Form

Contact Optima Medicare at 1-855-547-7740 (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.

**To Enroll in Optima Medicare HMO, Please Provide the Following Information:**

**1.** Select the plan you want to enroll in. Each plan option includes prescription drug coverage.

☐ **Optima Medicare Value (HMO)** $0 premium per month

☐ **Optima Medicare Prime (HMO)** $85 premium per month

**Effective Date Requested:** ___________

**2.** Choose dental coverage. Preventive Dental is automatically included, or choose an option with more coverage.

☑ Preventive Dental No additional cost

☐ Preventive Plus Additional $13.50

☐ Comprehensive Additional $16.00

The **Plan** premium plus the **Dental** cost is your **Total** cost per month.

$ ________ plan premium + $ ________ dental = $ ________ Total cost per month

| | | | |
|---|---|---|---|
| ☐ 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 select a Primary Care Physician from our 2019 Provider Directory: | | |

## 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 Medicare HMO.

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

☐ Electronic Funds Transfer (EFT) from your bank checking or savings account each month. Please enclose a VOIDED check or deposit slip, and provide the following in order for your auto deduction to be processed:

Account holder name: ______________________

Bank routing number: ______________________ Bank account number: ______________________

☐ Automatic deduction from your monthly 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

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 does not cover.

**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 Medicare HMO? ☐ 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:

☐ 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

☐ Moved back to the United States:________(date)

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

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

☐ No longer eligible for Extra Help paying for prescription drugs: ____________ (date)

☐ Recently moved outside of the area your plan covers: _____(date)

☐ Your Plan is ending its contract with Medicare

☐ Recently released from incarceration. _________ (date)

☐ Recently obtained lawful presence status in the U.S._________(date)

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

☐ 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): ______________________________

☐ No longer eligible for Special Needs Plan and was disenrolled: ____________ (date)

☐ Eligible for Open Enrollment Period. ☐ Other (please indicate reason):______________________

If these do not apply, please contact Optima Medicare HMO 1-855-547-7740 (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 Medicare HMO 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 Medicare HMO.** 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 Medicare HMO or by Medicare.

| **Signature:** | **Today's Date:** |
|---|---|
| | |

Legal Representative: Sign above and provide information below:

**Name:** ______________________________________________

**Address:** ______________________________________________

**Phone Number:** (______) __________ - __________________ **Relationship to Enrollee:** ____________________________

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

**Please Read Below**

Optima Medicare HMO is a Medicare Advantage plan and has a contract with the Federal government.

**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.

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

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