Medicare enrollment form

D-SNP

Thank you for choosing a Medicare D-SNP from Priority Health.

Please read the following before completing your application.

This 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 can enroll online, by using this paper form or contacting one of our Medicare experts at 833.352.4358. To enroll online as well as view our Provider/Pharmacy directory and formulary, visit ***priorityhealth.com/dsnp***.

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
  Reminder: If you want to join a plan during annual open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Within 3 months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans, known as a Special Enrollment Period (SEP).

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

Who can use this form?

People with Medicare who are also eligible for full Medicaid benefits who want to join a Dual Eligible Plan.

Priority Health D-SNP eligibility requirements:

1. You are enrolled in Medicare Parts A and B.
2. You are eligible for full Medicaid benefits, including:
   - Qualified Medicare Beneficiary (QMB+)
   - Specified Low-Income Medicare Beneficiary (SLMB+)
   - Other Full Benefit Dual Eligible (FBDE)
3. You reside within the plan's service area. *The counties **not** included are Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren and Wayne.*
4. You are a United States citizen or lawfully present in the United States; and
5. You are 21 years of age or older.

continued>

Enrollment Form checklist

☐ 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 ID number found on your MIHealth card.

☐ Sign and date the form.

Mail your completed enrollment form in the enclosed postage-paid envelope. Or, 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. You may also scan the completed form and email it to ***PH-MedicareEnrollment@priorityhealth.com***.

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 833.352.4358 from 8 a.m.–8 p.m., seven days a week (TTY users should 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 Priority Health at 833.352.4358. TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

For 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 address.

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: within 3 months of first getting Medicare and 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.

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.

Choose one of the following:

☐ I am new to Medicare (example: recently enrolled in Medicare Parts A and B).

☐ I had Medicare prior to now, but I am now turning 65.

☐ I am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).

☐ 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 am leaving or recently lost employer or union coverage on (insert date) (MM/DD/YYYY) ____ /____ /_____ (example: retiring and losing coverage through an employer).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost or will lose this drug coverage on (insert date) _____/_____/_____.

☐ 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: new to 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: new to extra help, had a change in the level of extra help, or lost extra help).

☐ I belong to a pharmacy assistance program provided by any state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I recently left a PACE program on (insert date) ____ /____ /_____.

☐ 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 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 returned to the United States after living permanently outside of the U.S.. I returned to the U.S. on (insert date) ____ /____ /_____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____ /____ /_____.

☐ I recently was released from incarceration. I was released on (insert date) ____ /____ /_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the 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 at 833.352.4358 (TTY users should call 711), 8 a.m.–8 p.m., seven days a week.

To enroll in a Priority Health D-SNP, please provide the following information:

Last name	First name	M.I. (optional)

Birth date ____/____/_____ MM DD YYYY	Sex ☐ M ☐ F

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

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

City	County	State	ZIP code

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

City	County	State	ZIP code

Email address (optional)	Check the box below to opt-in to receiving certain plan documents by email. ☐ Annual Notice of Change document

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: _____

Medicare and Medicaid 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.

1. Are you enrolled in Michigan's Medicaid program?

   ☐ No ☐ Yes, my Medicaid number is: _____

You must provide this important information to enroll in a Priority Health D-SNP.

Additional questions

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

List your Primary Care Physician (PCP).
First name of doctor: _____ Last name of doctor: _____

Do you work? ☐ Yes ☐ No Does your spouse (if applicable) work? ☐ Yes ☐ No

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: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Priority Health at 833.939.0983 (TTY 711) if you need information in an accessible format other than what's listed above. From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. You can also log into your member account at ***priorityhealth.com*** to send us a message.

Paying your plan premium

PriorityMedicare D-SNP 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. For 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.

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: _____/_____/_____
A paper form can only be accepted with a handwritten signature. Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

If you are the authorized representative, sign the previous page and complete the following fields:

Name: _____

Street address: _____

City:_____State:_____ ZIP: _____

Phone number: (_____) _____- _____

Relationship to Enrollee:
☐ Power of attorney
☐ Guardian
☐ Conservator

To help keep our records up-to-date and/or if additional actions need to take place on behalf of the member once enrolled, you may provide documentation to help verify legal guardianship agreements by either scan and email or mail legal documents to: Priority Health, MS 1115, 1231 E. Beltline Ave NE, Grand Rapids, MI 49525 or email ***MedicareCS@priorityhealth.com***. You may also create a member account and send the documentation via secure message.

For individuals and agents 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: _____Date: _____/_____/_____

Agent information

Referring agent number: _____

Referring agent National Producer Number: _____

Field Market Organization (FMO) name *(if applicable)*: _____

Agent received application on: _____/_____/_____

FMO received application on *(if applicable)*: _____/_____/_____

Scope of Appointment completed: ☐ Yes (Date completed: _____/_____/_____)
☐ No (Reason: _____)

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.

Important
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See the "Enrollment form checklist" on the first page to send your completed form to 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 0938-1378. 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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