OMB No. 0938-1378
Expires: 7/31/2023

CommuniCare ADVANTAGE

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?
People with Medicare who want to join the CommuniCare Advantage Chronic Condition Special Needs Plan (CSNP)

To join this plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have diabetes mellitus, cardiovascular disease, or congestive heart failure

Important - To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans, such as a special enrollment period for individuals with chronic conditions covered by this plan

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

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

How do I get help with this form?
Call CommuniCare Advantage at (855) 969-5869. TTY: 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a CommuniCare Advantage al (855) 969-5869 TTY:711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

What happens next?
Your completed and signed form needs to go to:
CommuniCare Advantage
PO Box 94038
Lubbock, TX 79493-4038

Once CommuniCare Advantage processes your request to join, you will be notified. CommuniCare Advantage is an HMO with a Medicare contract. Enrollment in this plan depends on contract approval.

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

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Section 1 – All fields on this page are required (unless marked optional)

Plan you want to join:

❑ CommuniCare Advantage Chronic Special Needs Plan (CSNP)

FIRST name:	LAST name:	(Optional) Middle Initial:

Birth date: (MM/DD/YYYY) (_ _/_ _/_ _ _ _)	Sex: ◯ Male ◯ Female	Phone number: ( )

Permanent residence street address (Don't enter a P.O. Box):

City:	(Optional) County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street Address: _____

City:_____ State:_____ ZIP Code: _____

Your Medicare Information:

Medicare Number: __ __ __ __ – __ __ __ – __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CommuniCare Advantage?

❑ Yes ❑ No

Name of other Coverage:	Member number for this coverage:	Group number for this coverage:
_____	_____	_____

Do you have one of the Plan's specified chronic conditions?

❑ Diabetes ❑ Cardiovascular Disease ❑ Congestive Heart Failure

Please note: CommuniCare Advantage will verify this qualifying condition with your provider's office.

Name of Provider/Provider Office:_____

Address: _____

City: _____State: _____ZIP Code:_____

Phone Number: ( ) _____

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IMPORTANT - Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in CommuniCare Advantage • By joining this Medicare Advantage Plan, I acknowledge that will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). • Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. • I understand I will have the right to appeal service and payment denials made by the plan. • 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. • I understand that when my CommuniCare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CommuniCare Advantage. Benefits and services provided by CommuniCare Advantage and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CommuniCare Advantage will pay for benefits or services that are not covered. • I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.	
Signature: _____	**Today's Date:** _____
If you're the authorized representative, sign above and fill out these fields:	
First Name: _____ Last Name: _____ Phone number: ( ) _____	Address:_____ City: _____State: _____ ZIP Code: _____ Relationship to enrollee: _____

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Section 2 – All fields on this page are optional

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

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large Print ☐ Audio CD

Please contact CommuniCare Advantage at (855) 969-5869 (TTY: 711) if you need information in a different language or a different accessible format. Our office hours are 8:00 a.m. – 8:00 p.m. seven days a week October 1 to March 31 (8:00 a.m.–8:00 p.m. Monday through Friday April 1 to September 30)

Do you work? ◯ Yes ◯ No	Does your spouse work? ◯ Yes ◯ No

List your primary care physician (PCP), clinic, or health center:

Name of provider:_____

Name of healthcare facility/clinic (if applicable): _____

Address:_____ City:_____ State:_____ ZIP Code:_____

Paying your plan premiums

You can pay your monthly Part D plan premium (including any late enrollment penalty that you currently have or may owe) by mailing a check, or online with a credit/debit card or electronic funds trAansfer from your bank account.

You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to you plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay CommuniCare Advantage the Part D-IRMAA.

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.

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment): _____
Effective Date of Coverage: _____ Not Eligible: _____
ICEP/IEP: _____ AEP: _____SEP (specify): _____

CommuniCare Advantage

www.communicare-advantage.com

Chronic Condition Special Needs Plan (CSNP) Pre-Qualification Form

CommuniCare Advantage Chronic Condition Special Needs Plan (CSNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. It is a plan designed for people with certain chronic or disabling conditions.

You may be eligible to join our CSNP if you can answer YES to any of the questions below. CommuniCare Advantage will need to obtain verification of the chronic condition from your provider's office within 30 days of enrollment. We are required to disenroll you from the Special Needs Plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your provider's office know that we will require their verification and that you provide us with accurate contact information for your provider's office at the bottom of this form.

CHF/CVD/Diabetes:

Has your primary care provider or other licensed health care professional diagnosed you with any of the following medical conditions? *(Check all that apply):*

Congestive Heart Failure (CHF) ◯ *YES* ◯ *NO* **Cardiovascular Disease (CVD)** ◯ *YES* ◯ *NO* **Diabetes** ◯ *YES* ◯ *NO*

CHF:

Do you have fluid in your lungs?	◯ *YES* ◯ *NO*
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	◯ *YES* ◯ *NO*
Do you take medication for the fluid in your lungs or to help your heart beat stronger?	◯ *YES* ◯ *NO*

CVD:

Have you had a heart attack or been told by your doctor you are at risk to have one?	◯ *YES* ◯ *NO*
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	◯ *YES* ◯ *NO*
Do you take medication for your heart or circulation?	◯ *YES* ◯ *NO*

Diabetes:

Do you check your blood sugar at home?	◯ *YES* ◯ *NO*
Do you have high blood sugar?	◯ *YES* ◯ *NO*
Do you take medicine to control your blood sugar?	◯ *YES* ◯ *NO*

Doctor/Healthcare Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name: _____ FIRST Name: _____

Telephone #: _____ Fax #: _____

Beneficiary Information:

Beneficiary Signature: _____ **Date: _____**

MM DD YYYY

LAST Name: _____ FIRST Name: _____

CommuniCare ADVANTAGE

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD
CommuniCare Advantage Chronic Condition Special Needs Plan

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period form October 15 – 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 if the statement 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.

- ❑ I have diabetes mellitus, congestive heart failure, and/or cardiovascular disease and qualify for a special enrollment period for individuals with chronic conditions covered by this plan.
- ❑ I am new to Medicare.
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently was released from incarceration. I was released 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 had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (circle one: newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ❑ 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 am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ❑ I recently left a PACE program on (insert date) _____.
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ❑ I am leaving employer or union coverage on (insert date) _____.
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ 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 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 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 applies to you or you're not sure, please contact CommuniCare Advantage at (855)-969-5869 (TTY: 711) to see if you are eligible to enroll. CommuniCare Advantage is an HMO with a Medicare contract. Enrollment in this plan depends on contract approval. We are open from 8:00 a.m. – 8:00 p.m. seven days a week October 1 to March 31 (8:00 a.m.–8:00 p.m. Monday through Friday April 1 to September 30).

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment): _____
Effective Date of Coverage: _____ Not Eligible: _____
ICEP/IEP: _____ AEP: _____SEP (OEPI or specify other): _____