PPHP
PROVIDER PARTNERS HEALTH PLAN

901 Elkridge Landing Rd., Ste. #100
Linthicum Heights, MD 21090
1-800-405-9681 TTY 711

www.pphealthplan.com

PPHP HMO SNP Individual Enrollment Request Form Please contact PPHP if you need information in another language or format (Large Print).

To Enroll in PPHP, Please Provide the Following Information:			
Last Name	First Name	Middle Initial	❑ Mr. ❑ Mrs. ❑ Ms.
Date of Birth (MM/DD/YYYY)	Sex ❑ M ❑ F	Home Phone Number	
Permanent Residence Street Address			
City	County	State	Zip
Mailing Address (Only if different from Permanent Residence Address) Street	City	State	Zip
Emergency Contact	Phone Number	Relationship to You	
E-mail Address			

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill in this information as it appears on your Medicare card

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:_____

Is Entitled To: Effective Date:

HOSPITAL (Part A)_____

HOSPITAL (Part B)_____

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

Paying your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe)] by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, 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 RRB. DO NOT pay PPHP 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 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 doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- ❑ Get a bill each month

- ❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

  I get monthly benefits from: o Social Security o RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Read and Answer These Important Questions

1. Do you have End-Stage Renal Disease (ESRD)? ❑ Yes ❑ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. 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 PPHP? ❑ 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**
_____	_____	_____

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No
If "yes," please provide the following information:

Name of Institution: _____ Date of Admission: _____

Address & Phone Number of Institution (number and street): _____

_____

4. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ❑ Yes ❑ No

6. Please choose the name of a Primary Care Physician, Clinic or Health Center:

7. Please check the space below if you would prefer us to send you information in a language other than English or in another format:

_____ Large Print
_____ Spanish
_____ Other

Please contact PPHP at 1-800-405-9681 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. seven days a week. TTY users should call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining PPHP could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PPHP. 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:

PPHP is a Medicare Advantage plan and has 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 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 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: October 15 – December 7 of every year), or under certain special circumstances.

PPHP serves a specific service area. If I move out of the area that PPHP 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 PPHP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from PPHP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date PPHP coverage begins, I must get all of my health care from PPA, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PPA and other services contained in my PPHP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PPHP WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with PPHP, he/she may be paid based on my enrollment in PPHP.

Release of Information: By joining this Medicare health plan, I acknowledge that PPHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that PPHP 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: _____

Address: _____

Phone Number: (_____)_____

Relationship to Enrollee: _____

Provider Partners Maryland Advantage (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-405-9681 (TTY: 711).

Provider Partners Maryland Advantage (HMO SNP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-405-9681 (TTY: 711).

Provider Partners Maryland Advantage (HMO SNP) è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso. ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-405-9681 (TTY: 711).

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (Type): _____ Not Eligible: _____

If form was completed at a Marketing event, put event ID here: _____

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 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.

- o I am new to Medicare.
- o 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)_____.
- o I recently was released from incarceration. I was released on (insert date)_____.
- o I recently returned to the United States after living permanently outside of the US. I returned to the US on (insert date) _____.
- o I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.
- o I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- o I get extra help paying for Medicare prescription drug coverage.
- o I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)_____.
- o 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)_____.
- o I recently left a PACE program on (insert date)_____.
- o I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.
- o I am leaving employer or union coverage on (insert date)_____.
- o I belong to pharmacy assistance program provided by my state
- o My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan
- o 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)_____.

If none of these statements applies to you or you're not sure, please contact PPHP at 1-800-405-9681 TTY users should call 711 to see if you are eligible to enroll. We are open 8am to 8 pm seven days a week.