PPHP
PROVIDER PARTNERS HEALTH PLANS

785 Elkridge Landing Rd., Ste. #300
Linthicum Heights, MD 21090
1-800-405-9681 TTY 711

www.pphealthplan.com

Provider Partners Health Plan Enrollment Form

Please contact **Provider Partners Health Plans (PPHP)** if you need information in another language or format (Braille).

To Enroll in Provider Partners Health Plans, Please Provide the Following Information:

Please check which plan you want to enroll in:

- ☐ Maryland Advantage $29.70 per month
- ☐ Pennsylvania Advantage $35.60 per month
- ☐ Illinois Advantage $26.00 per month
- ☐ Ohio Advantage $28.50

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 (P.O. Box is not allowed):

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 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 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

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _

Account type: ☐ Checking ☐ Saving

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

I get monthly benefits from: ☐ Social Security ☐ 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.)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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 accessible format:

_____ Spanish
_____ Large Print, Braille

Please contact PPHP at 1-800-405-9681 if you need information in an accessible format or language other than what is listed above. Our office hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.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 PPHP, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by PPHP 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: _____

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.

- ○ 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 US. I returned to the US 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 (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 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 PPHP at 1-800-405-9681 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.

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Authorization for Disclosure of Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires your providers to get your permissions before disclosing your personal health information. Completion of this document authorizes the disclosure for three specific purposes only.

Disclosure Authorization

This Authorization for Disclosure of Health Information allows my nursing facility/provider, _____ to disclose my personal health information only for the purpose of:

1) Preparing my health risk assessment
2) Preparing a personalized care plan prior to the effective date of my enrollment in the Provider Partners Health Plans.
3) Coordinating benefits and collaborating with all Providers for member's continuity of care with Provider Partners Health Plans

This authorization applies to all the health information maintained by the provider about my medical history or care from the date of admission into the nursing facility to the present relating to any specific treatment or services received.

I understand the following:

- This authorization expires if I fail to enroll in the plan or upon termination of my enrollment in the plan.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent to Provider Partners Health Plans.
- My personal health information will be used only for the purposes outlined above.
- This authorization is voluntary. I may refuse to sign this form without impact on any treatment, payment, enrollment, or eligibility for benefits based on my refusal to sign this authorization.
- Information disclosed according to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law.

Print Name of Applicant / Member / Authorized Representative Medicare ID number

Signature of Applicant / Member / Authorized Representative Date

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Witness Signature Date

If you are the authorized representative of the applicant, you must provide the following information:

Relationship to the Applicant

Address Telephone Number

For any questions regarding this form, please contact Member Services at 1-800-405-9681 (TTY 711). We are open 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.