



PROVIDER PARTNERS HEALTH PLANS ENROLLMENT REQUEST FORM

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

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

Visit [Medicare.gov](https://www.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

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.

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.

What happens next?

Send your completed and signed form to:

Provider Partners Health Plans
785 Elkridge Landing Rd
Suite 300
Linthicum Heights MD 21090

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Provider Partners Health Plans at 1-800-405-9681. TTY users can 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 Provider Partners Health Plan al 1-800-405-9681 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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 information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, 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.

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 "What happens next?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

- | | | |
|---|---|---|
| <input type="checkbox"/> Provider Partners Maryland Advantage Plan (HMO SNP)
\$32.30 per month | <input type="checkbox"/> Provider Partners Pennsylvania Advantage Plan (HMO SNP)
\$37.50 per month | <input type="checkbox"/> Provider Partners Ohio Advantage Plan (HMO SNP)
\$29.80 per month |
| | <input type="checkbox"/> Provider Partners Illinois Advantage Plan (HMO SNP)
\$27.40 per month | <input type="checkbox"/> Provider Partners Missouri Advantage Plan (HMO SNP)
\$30.50 per month |

FIRST name: _____ LAST name: _____ Middle Initial: _____

Birth date: (MM/DD/YYYY) (__ __/__/____)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone number: ()
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Permanent Residence street address (Don't enter a PO Box):

City:	County:	State:	ZIP Code:
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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 Provider Partners Health Plans?
 Yes No

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

Are you a resident in a long-term care facility? Yes No

If "yes," please provide the following information: _____

Name of Institution: _____

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

IMPORTANT: Read and sign below:

- ^ I must keep both Hospital (Part A) and Medical (Part B) to stay in Provider Partners Health Plans.
- ^ By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Provider Partners Health Plans 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.
- ^ 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 Provider Partners Health Plans coverage begins, I must get all of my medical and prescription drug benefits from Provider Partners Health Plans. Benefits and services provided by Provider Partners Health Plans and contained in my Provider Partners Health Plans “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Provider Partners Health Plans 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:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields on this page are optional

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

Select one if you want us to send you information in a language other than English.

Spanish

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

Braille Large print

Please contact Provider Partners Health Plans at 1-800-405-9681 if you need information in an accessible format other than what's listed above. 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 can call 711.

Do you work? Yes No

Does your spouse work? Yes No

List your Primary Care Physician (PCP), clinic, or health center:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) each month. 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 your 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 *Provider Partners Health Plans* the Part D-IRMAA.

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 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.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

<p>Office Use Only:</p> <p>Name of staff member/agent/broker (if assisted in enrollment): _____</p> <p>Plan ID # _____ Date application received _____</p> <p>Effective Date of Coverage: _____</p> <p>ICEP/IEP: _____ AEP: _____ SEP (Type): _____ Not Eligible: _____</p> <p>If the form was completed at a Marketing event, put event ID here: _____</p>
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