Enrollment Form Instructions

To be eligible for Mercy Care Advantage (HMO SNP), you must receive Medicaid medical assistance from the State of Arizona, have Medicare Parts A and B, be a United States citizen or be lawfully present in the U.S. and reside in the Plan approved service area.

Our Plan service areas for the following Medicaid programs include:

AHCCCS Complete Care (ACC)	Gila, Maricopa, and Pinal counties
ALTCS	Gila, Maricopa, Pima and Pinal counties
Arizona Division of Developmental Disabilities	All counties in the State of Arizona

If you lose your Medicare or Medicaid eligibility, Mercy Care Advantage is required to end your coverage.

SECTION 1 (REQUIRED):

- Complete your Name (as it reads on your Medicare Card), Date of Birth, Telephone number, and Permanent Residence address.
- If you want to join our plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic or the address where you receive mail may be considered your permanent residence address.
- Complete your e-mail address (optional).
- Complete the Mailing Address only if your mail is delivered to a different address.
- Provide your Medicare health insurance information from your Medicare card or attach a copy of your Medicare card or other proof of Medicare eligibility.
- Please read and answer the question regarding other prescription drug coverage.
- Provide your Medicaid health insurance information from your AHCCCS ID card.
- Read your agreement carefully; it is important for you to understand your rights and responsibilities as a Mercy Care Advantage member.
- Sign and date your application.
    - Authorized Representatives: If you have legal authorization to sign on the enrollee's behalf, please provide your contact information in the area indicated on the last page. It is recommended that you include a copy of the legal documentation (e.g. Durable General Power of Attorney; Legal Guardianship; or Conservatorship) so that we can record this information in our systems for future interactions you will have with our plan on behalf of the enrollee.

SECTION 2 (OPTIONAL):

- Please tell us if you are a resident of a nursing home or long-term care facility.
- Please tell us if you or your spouse are working.
- Write in the name of your Primary Care Physician (PCP) – refer to the Mercy Care Advantage Provider/Pharmacy Directory. If you do not select a PCP, we will assign one located near where you live.
- Tell us if you need plan information in a language other than English (or in an accessible format).
- Please read the Privacy Act Statement.
- Please read and complete the Attestation of Enrollment Eligibility Period section. During the last quarter of the year, the Medicare Annual Election Period (AEP) **(October 15th through December 7th)**, allows you to make a Plan election for a January 1 effective date. If you are enrolling outside of AEP, there are Special Election Periods (SEP) for Dual Eligible Beneficiaries that may apply to your enrollment situation. Please check the boxes that apply to you. If we need additional information, a representative will contact you.

Return your completed Enrollment form in the Self-Addressed Postage Paid envelope provided or fax it to 602-431-7499.

Should you have questions or need help completing this form, please call:

602-414-7630 or **1-866-571-5781** (TTY **711**)
8:00 a.m. – 8:00 p.m., 7 days a week

Mercy Care Advantage is an HMO SNP with a Medicare contract and a contract with the Arizona Medicaid Program. Enrollment in Mercy Care Advantage depends on contract renewal.

mercycareaz.org
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Phone: 602-414-7630
Toll Free: 1-866-571-5781 (TTY **711**)
Fax: 602-431-7499

mercy care advantage HMO SNP

SECTION 1 All fields in Section 1 are required (unless marked optional)

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

Birth Date:	Sex:	Home Phone Number:
(_ _/_ _/_ _ _ _) MM/DD/YYYY	☐ M ☐ F	(__ __ __) __ __ __ - __ __ __ __ Alternate Phone Number: (__ __ __) __ __ __ - __ __ __ __

PERMANENT RESIDENCE STREET ADDRESS (Don't enter a P.O. Box):

Street Address (P.O. Box is not allowed. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

City:	State:	ZIP Code:

(Optional) County:

(Optional) **EMAIL ADDRESS:** _____

MAILING ADDRESS if different from your Permanent Address (P.O. Box allowed)

Street Address or P.O. Box:

City:	State:	ZIP Code:

Your Medicare Information

MEDICARE NUMBER:

Name (as it appears on your Medicare card):	**Effective Date**
	HOSPITAL (Part A) _____/_____/_____
_____	MEDICAL (Part B) _____/_____/_____

Answer These Important Questions

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

☐ Yes ☐ No If Yes, provide the information below:

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

Your State Medicaid Information

To enroll in Mercy Care Advantage, you must be Medicaid eligible. Please provide the following information:

Are you receiving Medicaid (AHCCCS) Medical Assistance from the State of Arizona? ☐ Yes ☐ No

If Yes, provide your **AHCCCS Medicaid ID Number:** _____

Please check the Medicaid/AHCCCS program that applies to you:

☐ 001 – AHCCCS Complete Care (ACC) ☐ 004 – ALTCS ☐ 005 – DDD

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Mercy Care Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that Mercy Care Advantage 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 that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand when my Mercy Care Advantage coverage begins, I must get all of my medical and prescription drug benefits from Mercy Care Advantage. Benefits and services provided by Mercy Care Advantage and contained in my Mercy Care Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Mercy Care Advantage will pay for benefits or services that are not covered.
- 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 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 from Medicare.

Signature of applicant/member/authorized representative:	**Today's Date:**

SECTION 2 All fields in Section 2 are optional.

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

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: _____

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

_____

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

Please select a **Primary Care Physician (PCP), clinic, or health center** from the Mercy Care Advantage provider directory. You must receive all routine care from network providers.

Name _____ Are you a current patient? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Other _____ ☐ Audio ☐ Large Print ☐ Braille

Please contact Mercy Care Advantage at 602-414-7630 or 1-866-571-5781 (TTY 711) if you need information in an accessible format other than what is listed above. Our office hours are 8:00 a.m.– 8:00 p.m., 7 days a week.

Attestation of Enrollment Eligibility 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.

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 have new options available to 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 (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)_____.
- ❒ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ❒ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ❒ 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 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 applies to you or you're not sure, please contact Mercy Care Advantage at **602-414-7630** or **1-866-571-5781**, (TTY users should call **711**) to see if you are eligible to enroll.
We are open 8:00 a.m. – 8:00 p.m., 7 days a week.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Address:
Phone number:	Relationship to enrollee:

Signature:

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):		National Producer Number (Agents/Brokers only):
Date Received:	Plan ID#	Proposed Effective Date of Coverage: (_ _/_ _/_ _ _ _) MM/DD/ YYYY

Select Appropriate Election Period

☐ ICEP/IEP-D ☐ MA-OEP ☐ SEP (type) _____ ☐ AEP ☐ OEPI ☐ Not Eligible

☐ ALTCS-HCBS SSBCI

Processed By:		Date Processed:	(_ _/_ _/_ _ _ _) MM/DD/ YYYY