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: (_ _/_ _/_ _ _ _) MM/DD/YYYY	Sex: ☐ M ☐ F	Home Phone Number: (__ __ __) __ __ __ - __ __ __ __ Alternate Phone Number: (__ __ __) __ __ __ - __ __ __ __
PERMANENT RESIDENCE STREET ADDRESS (Don't enter a P.O. Box):		
Street Address (P.O. Box is not allowed):		
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 <u>prescription</u> drug coverage (like VA, TRICARE) in addition to Mercy Care Advantage? ☐ Yes ☐ No		
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 Numbe**r: _____

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:	**Today's Date:**

If you are the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

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.

1. 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) _____
   _____

2. 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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.
☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	

☐ **I choose not to answer.**

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.

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 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 (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 apply to you or you're not sure, please contact Mercy Care Advantage at **602-414-7630** or **1-866-571-5781**, (TTY **711**) to see if you are eligible to enroll.
We are open 8:00 a.m. – 8:00 p.m., 7 days a week.

Office Use Only:

Name of staff member, agent, broker (if assisted in enrollment):		Date rec'd:
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		
Processed by:		Date Processed: (_ _/_ _/_ _ _ _) MM/DD/YYYY