Pre-Enrollment Checklist

Health CHOICE PATHWAY

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-656-8991, TTY 711,** 8 a.m. – 8 p.m., 7 days a week.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **HealthChoicePathway.com,** or call **1-800-656-8991,** TTY **711** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure the prescription medicines you use are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/co-insurance may change on January 1, 2022.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

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Attestation of Eligibility for an Enrollment Period

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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.

Attestation of Eligibility for an Enrollment Period

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☐ 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 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 Health Choice Pathway (HMO D-SNP) at **1-800-656-8991** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m., 7 days a week.

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OMB No. 0938-1378 Expires: 7/31/2023

Enrollment Request Form

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Who can use this form?

People with Medicare who want to join a Medicare Advantage 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 (Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties)

Important: To join this Medicare Advantage Special Needs Plan, you must also have:
- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicaid (AHCCCS)

When do I use this form?

You can join a plan:
- Between October 15–December 7 each year (for coverage starting January1)
- Starts 3 months before you get Medicare, the month that you become eligible for Medicare and 3 months after your Medicare becomes effective
- You're allowed to join or switch plans in certain situations

Visit 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 Medicaid (AHCCCS) 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:
By Mail: Health Choice Pathway (HMO D-SNP)
Attn: Enrollment Dept.
410 N. 44th Street, Suite 900
Phoenix, AZ 85008
By fax: 480-760-4635
By email:
HCHPathwayEnrollment@HealthChoiceAZ.com

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

How do I get help with this form?

Call Health Choice Pathway at **1-800-656-8991.** TTY users can call **711.** 8 a.m. to 8 p.m., 7 days a week. Or, call Medicare at 1-800-MEDICARE **(1-800-633-4227).** TTY users can call **1-877-486-2048.**
En español: Llame a Health Choice Pathway al **1-800-656-8991, 711,** 8:00 a.m. to 8:00 p.m., los 7 dias de la semana o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

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

Select the plan you want to join: ☐ Health Choice Pathway – $0 - $30.70 per month

Name (as it appears on your Medicare card)

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

Birth date: (MM/DD/YYYY)	Sex:	Mobile phone number:
(/ /)	☐ Male ☐ Female	( ) Alternate phone number: ( )

Permanent Residence street address (Don't enter a PO Box):

_____

City: _____ State: _____ ZIP Code: _____ County: _____

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 Health Choice Pathway? ☐ Yes ☐ No

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

1. Are you enrolled in your State Medicaid program (AHCCCS)? ☐ YES ☐ NO

   If yes, please provide your Medicaid number: _____

2. 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: _____

IMPORTANT: Read and sign below:

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

Please contact Health Choice Pathway at **1-800-656-8991** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. 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:

_____

Address: _____

☐ By checking this box, I agree to opt in to receive emails and/or texts with information about my enrollment, health programs and other plan services. I understand I may change my email and text preferences and opt out at any time by calling **1-800-656-8991,** TTY **711.**

E-mail address: _____

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 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 Health Choice Pathway the Part D-IRMAA.

OFFICE USE ONLY:

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

Agent/broker number: _____

Date enrollment form was received if mailed/faxed to Agent: _____

Effective date of coverage: _____

ICEP/IEP: ☐ AEP: ☐ SEP (type): ☐ Not Eligible: ☐

Paper enrollment: ☐ Telephonic enrollment: ☐ Electronic enrollment: ☐

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.

Submit