Magellan COMPLETE CARE®

Individual Enrollment Form

Magellan Complete Care of Arizona, Inc. (MCC of AZ) (HMO SNP)

Please contact MCC of AZ (HMO SNP) if you need information in another language or format (Braille).

To enroll in MCC of AZ (HMO SNP), please provide the following information:			
Last name: First name: Middle initial:			☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: (____/_____/_____) (MM / DD / YYYY)	Sex: ☐ M ☐ F	Home phone number: ( )	Alternate phone number: ( )
Permanent residence street address (P.O. Box is not allowed):			
City:	County:	State:	ZIP code:
Mailing address (only if different from your permanent residence address): Street address: _____ City: _____ State: _____ ZIP code: _____			
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 the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare number: _____ Is entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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 MCC of AZ (HMO SNP)? ☐ **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: _____

Address (number-street-city-state): _____

Phone number: ( ) _____

4. Are you enrolled in your State Medicaid program? ☐ **Yes** ☐ **No**

If yes, please provide your Medicaid number:

5. Medicaid existing benefits & services: Do you receive the following home-based services?

Service	Yes	No
Personal Care Attendant (PCA)		
Home Health Aide (HHA)		
Personal Care Services(PC)		
Adult Foster Care (AFC)		
Group Adult Foster Care (GAFC)		
Adult Day Health with Transportation		
Dementia Day Care		
Day Rehabilitation Services		
Respite Care		
Wander Response System		

Service	Yes	No
Chore Services		
Homemaker		
Laundry		
Grocery shopping/ Delivery Services		
Home Delivered Meals		
Personal Emergency Response System (PERS)/Lifeline		
Social Day Care Services		
Incontinence briefs		
Supplements		
Companion Services		

6. Do you or your spouse work? ☐ **Yes** ☐ **No**

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

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:

☐ Braille ☐ Audio tape ☐ Large print

Preferred language: _____

Written language: _____

Please contact MCC of AZ (HMO SNP) at 1-800-424-4509 (TTY 711) if you need information in an *accessible* format or language *other* than what is listed above. Our office hours are 8 a.m. to 8 p.m., Monday through Friday (from October 1-March 31, 7 days a week).

Please Read This Important Information

If you currently have health coverage from an employer or union, joining MCC of AZ (HMO SNP) could affect your employer or union health benefits. You could lose your employer or union health coverage if you join MCC of AZ (HMO SNP). 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:

MCC of AZ (HMO SNP) 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.

I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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:

- Under certain special circumstances OR
- During the annual open enrollment period (October 15-December 7 of every year) OR
- When there is a Special Election Period (SEP) for individuals who have both Medicare Parts A and B and receive any type of assistance from Medicaid.

The SEP starts the month you become dually eligible and continues as long as you receive Medicaid benefits. However, there are limits in how often it can be used. The SEP allows an individual to enroll in, or disenroll from, an MA plan once per quarter during the first nine months of the calendar year. That means the SEP can be used one time during each of the following time periods:

- January-March
- April-June
- July-September

It may not be used in the 4th quarter of the year (October-December). From October 15 to December 7, you can join, switch or drop a Medicare health or drug plan for an effective date of January 1 of the following year.

When you make a request using the SEP, your enrollment status is effective the first day of the month following receipt of the request. The SEP is considered used during the month it is requested.

MCC of AZ (HMO SNP) serves a specific service area. If I move out of the area that MCC of AZ (HMO SNP) 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 MCC of AZ (HMO SNP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from MCC of AZ (HMO SNP) 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 MCC of AZ (HMO SNP) coverage begins, I must get all of my health care from MCC of AZ (HMO SNP), except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by MCC of AZ (HMO SNP) and other services contained in my MCC of AZ (HMO SNP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR MCC of AZ (HMO SNP) 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 MCC of AZ (HMO SNP), he/she may be paid based on my enrollment in MCC of AZ (HMO SNP).

Release of Information: By joining this Medicare health plan, I acknowledge that MCC of AZ (HMO SNP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MCC of AZ (HMO SNP) 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: _____