



PartnershipAdvantage (HMO SNP)

Office Use Only: Representative Name
Effective Date of Coverage: _____ / _____ / _____
Date Received: _____ / _____ / _____
() ICEP/IEP () AEP () SEP () Not Eligible

Please contact PartnershipAdvantage if you need information in another language or format (Braille).

To Enroll in PartnershipAdvantage, Please PRINT the Following Information


Last Name		First Name		Middle Initial
Permanent Residence Address <i>(P.O. Box is not allowed):</i>		City	State	Zip Code
Mailing Address <i>(if different from above)</i>		City	State	Zip Code
Home Phone Number	Alternate Phone Number	Date of Birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

Please Provide Your Medicare Health Insurance Claim Number

Please take out your Medicare card to complete this information

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR-
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

	
SAMPLE ONLY	
Name: _____	Sex _____
Medicare Claim Number _____ - _____ - _____	Effective Date _____
Is Entitled To HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Would you like us to send you information in another language or format?

- Other Language: Spanish Other _____
- Other Format: Large Font Braille Audio CD Other _____

Please contact PartnershipAdvantage at 1 (866) 249-9933 if you need information in another format or language than what is listed above. Our office hours are 8am to 8pm 7 days a week. TTY users should call 1 (800) 735-2929 or call 711.

Do you need interpreter services when you receive medical care? Yes No

Please Read, Answer the Following Questions, and Sign Below

Do you have End Stage Renal Disease (ESRD)? Yes No

Diagnosis Date: ____/____/____ (MM/DD/YYYY)

If you answered “yes” to this question and you don’t need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records from your doctor** showing you don’t need dialysis or have had a successful kidney transplant.

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 Partnership*Advantage* (HMO SNP)?
 Yes No

If “yes,” please list your other coverage and your identification numbers for this coverage:
(Please do not list your current Part D or Medicare Advantage Plan. Partnership*Advantage* will replace your current Part D or Medicare Advantage Plan.)

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

Do you currently receive Medi-Cal benefits from the State of California?

•You must have full-scope Medi-Cal, with no “share-of-cost” to enroll in Partnership*Advantage*.

Yes No If yes, please provide your ID # on your Purple and White PHC ID Card:
ID # _____

Please choose a Primary Care Physician (PCP) from the Partnership*Advantage* Provider Directory. If you do not choose a PCP at the time of enrollment, you may be automatically assigned to your current PHC Medi-Cal provider.

PCP Name: _____ PCP ID # (found in the Provider Directory): _____

STOP! Please Read This Important Information



If you currently have health coverage from an employer or union, joining Partnership*Advantage* could affect your employer or union health benefits. You could lose your employer or union health cover-ages if you join Partnership*Advantage*. 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.

By completing this enrollment application, I agree to the following: Partnership*Advantage* (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, and full-scope, no share-of-cost Medi-Cal. 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. 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 when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances. If I continue to qualify for Extra Help, I may change plans at any time during the year. Partnership*Advantage* serves a specific service area. If I move out of the area that Partnership*Advantage* services, 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 Partnership*Advantage*, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Partnership*Advantage* 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 Partnership*Advantage* begins, I must get all of my health care from Partnership*Advantage*, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Partnership*Advantage* and other services contained in my Partnership*Advantage* Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PARTNERSHIPADVANTAGE 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 Partnership*Advantage*, he/she may be paid based on my enrollment in Partnership*Advantage*.

Release of Information: By joining this Medicare health plan, I acknowledge that Partnership-*Advantage* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Partnership*Advantage* 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 and 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.

Please Read this Document Prior to Signing the Application Below

Your Signature: _____ Today's Date: _____

If you are the "Authorized Representative," you must provide the following information:

Name: _____ Relationship to beneficiary: _____

Address: _____ Phone Number: (____) _____ - _____

City: _____ State: _____ Zip Code: _____