

CareAdvantage Cal MediConnect Plan (Medicare–Medicaid Plan) Application Form

You can join CareAdvantage if you: Live in San Mateo County, Have Medicare Parts A & B, Have full-scope Medi-Cal

To join **CareAdvantage** either;

- Call HPSM toll-free at **1-888-252-3153** or
- Print, fill-out, sign, and return this form to HPSM by one of these three methods:

Mail:

Health Plan of San Mateo
C/O Marketing
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

Email:

Photograph or scan each page
and send as an attachment to
customersupport@hpsm.org

Fax:

650-616-2190

or

or

After your application is received, HPSM will call you to let you know if your CareAdvantage membership is approved or if we need more information.

Tell us about yourself:

*First Name		Middle Initial	*Last Name		
	Male	Female			
*Date of Birth	*Sex		Email Address		
Phone Number		Another phone number			
*Home address (address where you live)	City	State	Zip code	County (optional)	
Mailing Address (if different from home address)	City	State	Zip code	County (optional)	
Emergency contact name		Emergency contact phone			

If you are not a native English speaker, you can call **1-888-252-3153** to get this form in a different language. TTY users should call **1-800-735-2929** or dial **7-1-1** (California Relay Service).

Please select or enter your preference for speaking and reading:

Speak: English Spanish Tagalog Chinese Russian Other: _____
 Read: English Spanish Tagalog Chinese Russian Other: _____

Do you want us to send you member materials in your preferred language? Yes No

Do you want us to send you information about your plan and benefits in other formats?

Please specify format: Standard size Large print Braille Audio CD Other: _____

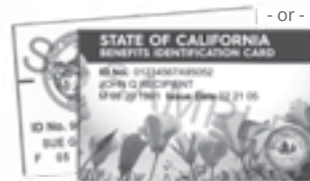
Name of your primary care provider (PCP), clinic, or health center

*Name

Phone number

Tell us about your Medicare and Medi-Cal coverage:

Fill in your Medicare and Medi-Cal information below. You can find this information on your red, white, and blue Medicare card, or a letter from Social Security or the Railroad Retirement Board. Also, please put your Medi-Cal ID number as it appears on the front of your card.



Medicare Number: _____

State Medi-Cal ID No.: _____

***Other personal information:**

Do you have End-Stage Renal Disease (ESRD)? Yes No If Yes, fill in the information below:

_____ Name of dialysis facility

_____ City of dialysis facility

If you've had a successful kidney transplant and/or no longer need regular dialysis, please include a note from your doctor.

Do you live in a long-term care facility? Yes No If Yes, fill in the information below:

_____ Name of long-term care facility

_____ Phone number of long-term care facility

Your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs. If you have health coverage from an employer, union, or other private or public health insurance right now, you will not be able to join CareAdvantage CMC.

Do you have other health coverage in addition to Medicare and Medi-Cal? Yes No

If Yes, fill in the information below:

_____ Name of your plan (and employer, if applicable)

_____ Group number:

_____ ID number:

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Please read and sign on following page

When you sign this form, it means that you understand:

- CareAdvantage Cal MediConnect Plan (Medicare-Medicaid Plan) has a contract with the federal government and with the State of California.
- The health services you get with your new plan may be different than the services you had before.
- I must keep Medicare Part A, Part B and have Medi-Cal through the Health Plan of San Mateo (HPSM).
- I can be in only one Medicare plan at a time.
- By joining CareAdvantage CMC, I will end my enrollment in another Medicare health or prescription drug plan.
- I must tell CareAdvantage CMC about any prescription drug coverage that I have or may get in the future.
- If I move, I need to tell CareAdvantage CMC.

- As a member of CareAdvantage CMC, I have the right to appeal if I don't agree with CareAdvantage CMC's decisions about payment or services.
- CareAdvantage CMC doesn't usually cover people while they're out of the country.
- On the date CareAdvantage CMC coverage begins, I must get my health care from CareAdvantage CMC doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get CareAdvantage CMC approval to see other providers.
- If I need to see a doctor or other provider who is not in CareAdvantage CMC, I may need prior authorization or I may have to pay out-of-pocket for the services I get.
- I understand that if a sales agent, broker, or other individual employed by or contracted with CareAdvantage CMC is helping me, CareAdvantage CMC may pay that person when they enroll me.
- By joining CareAdvantage CMC, I know that CareAdvantage CMC may share my information with Medicare and Medi-Cal and other plans as necessary for treatment, payment, and health care operations.
- I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll be able to receive at least one 30-day supply of the prescription drugs I currently take anytime during the first 90 days of coverage in CareAdvantage CMC.
- I understand that I may be able to continue seeing the doctors I go to now for a period up to twelve (12) months for Medicare services and a period of up to twelve (12) months for Medi-Cal services from the effective date of enrollment in CareAdvantage CMC. I must contact CareAdvantage CMC for information on how to do this. I further understand that CareAdvantage CMC has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations.
- I know that CareAdvantage CMC may share my information including my prescription drug information with Medicare and Medi-Cal. They may release it for research and other purposes, as allowed by Federal statutes and regulations.
- The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from CareAdvantage CMC.
- My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare or Medi-Cal.

*Your signature

*Date

If you are the authorized representative, you must provide the following information, sign, and date below:

Representative's name (please print)

Representative's signature

Representative's address

Relationship to enrollee

Representative's phone number

Today's date

If you have questions, call a licensed CareAdvantage Medicare Specialist at **1-888-252-3153**,

Monday through Friday 9:00 a.m. to 6:00 p.m. or visit www.hpsm.org/CareAdvantage

TTY users should call **1-800-735-2929** or dial **7-1-1** (California Relay Service). The call is free. This information is available for free in other languages and formats like Braille or audio CD.