HealthPlan OF SAN MATEO
Healthy is for everyone

Keep the yellow copy of this form for your records.
Questions marked with an asterisk (*) are required.

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

To join CareAdvantage Cal MediConnect Plan (Medicare–Medicaid Plan), you must have Medicare Part A, Medicare Part B, and Medi-Cal through the Health Plan of San Mateo (HPSM). You can also call **1-888-252-3153** to join CareAdvantage CMC. The call is free.

Tell us about yourself:

_____ _____ _____
*First Name Middle Initial *Last Name

m m / d d / y y y y ❑ Male ❑ Female _____
*Date of Birth *Sex Email Address

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Phone Number Another phone number

Address where you live:

_____ _____ _____ _____ _____
*Address City State Zip code County (optional)

Address where you get mail (if different from where you live):

_____ _____ _____ _____ _____
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 the form in a different language.
TTY users should call **1-800-735-2929** or dial **7-1-1** (California Relay Service).

What is your preferred language? (choose one)

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

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

Do you want us to send you materials in this language? ❑ Yes ❑ No

Do you want us to send you materials in other formats? (optional)

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

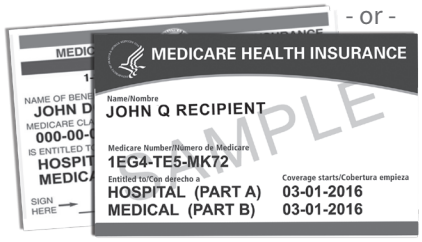
Name of your primary care provider (PCP), clinic, or health center

_____ (__ ___ ___) ___ ___ ___ - ___ ___ ___ ___
*Name Phone number

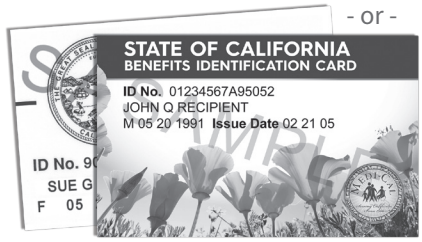
OFFICE USE ONLY S/Code _____ S SA Ref. Source _____

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.



- or -



- or -

*Medicare Number: _____ *State Medi-Cal ID No.: _____

Other personal information:

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

   Facility name: _____ City: _____

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

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

   Facility name: _____ Phone number: (__ __ __) __ __ __–__ __ __ __

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.

3. 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:
1		
2		

If you have health coverage from an employer or union or other private or public health insurance right now, you will not be able to join CareAdvantage CMC.

Please read and sign at end of section

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

For more information, visit www.hpsm.org/CareAdvantage. **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. 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.