

CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a plan with Medicare and Medi-Cal contracts. Enrollment in CareAdvantage D-SNP depends on contract renewal.

Filling out this application is your first step to getting access to a wide range of health care benefits and services. Plus, you can connect with a local team to help you use those benefits so you can stay healthy.

Joining CareAdvantage is easy. You can return this form to HPSM in three ways:

Mail:

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

or

Email:

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

or

Fax:

650-616-2190

Who can fill out this form? People with **only** Medicare Parts A & B and HPSM Medi-Cal health coverage

When do I use this form? You can fill out this form to join CareAdvantage:

- Between October 15 – December 7 every year (for coverage starting January 1 the following year)
- During the 3 months of first getting Medicare
- In some situations where you're allowed to join or switch plans (learn more at www.medicare.gov)

To join this plan, you must be a United States citizen or be lawfully present in the U.S. and live in San Mateo County.

What do I need to complete this form? You will need your Medicare number (from your red, white and blue Medicare card), your Medi-Cal number, your address and phone number. *If you have no permanent address, a post office box, address of a shelter or clinic, or address of where you receive any mail (social security checks, etc.) may be considered your permanent address.*

How do I get help with this form? HPSM's team of Medicare Specialists is ready to help you sign up for CareAdvantage. Call them at **1-888-252-3153** (toll free) or **650-616-1500** Monday through Friday from 9 a.m. to 6 p.m. TTY users call **1-800-735-2929** or dial **7-1-1**.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tell us about yourself (all fields are required unless marked optional):

First Name	Last Name	Middle Initial <i>(optional)</i>		
Date of Birth (MM/DD/YYYY)	Sex Male Female	Phone #		
Home Address <i>(where you live)</i>	City	State	Zip	County <i>(optional)</i>
Mailing Address <i>(if different from home address)</i>	City	State	Zip	County <i>(optional)</i>
Email Address	Emergency Contact	Emergency Contact Phone #		
Medicare # <i>(Found on the front of your Medicare card.)</i>		Medi-Cal # <i>(Found on the front of your HPSM ID card.)</i>		
Do you work?	Yes No	Does your spouse work?	Yes No	

Other Prescription Drug Coverage

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareAdvantage Yes No

Name of Coverage	Member ID#	Group ID#
Effective Date (MM/DD/YYYY)		

IMPORTANT: Read and sign to acknowledge you understand:

- I must keep both Medicare Parts A & B and HPSM Medi-Cal to stay in CareAdvantage.
- I can be enrolled in only one Medicare Advantage plan at a time. Enrollment in any other plan will automatically end when I enroll in CareAdvantage (exceptions are for MA PFFS, MA MSA plans).
- CareAdvantage 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). Your response to this form is voluntary, but failure to respond may affect your enrollment in CareAdvantage.
- When my CareAdvantage coverage begins, I must get all of my medical and prescription drug benefits from CareAdvantage. Benefits and services provided by CareAdvantage and contained in my Evidence of Coverage (EOC) (also known as Member Handbook) will be covered. Neither Medicare nor CareAdvantage will pay for benefits or services that are not covered.
- 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 will be disenrolled from CareAdvantage.
- My signature (or signature of the person legally authorized to act on my behalf) on this form means that I have read and understood this form. If signed by an authorized representative (as described previously), this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare or Medi-Cal.

Your Signature	Date
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Representative's name (please print)	Representative's signature
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Representative's address	City	State	Zip	County <i>(optional)</i>
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Relationship to enrollee	Representative's phone #	Today's date
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Other Information

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply

No, not of Hispanic, Latino/a, or Spanish origin

Yes, Puerto Rican

Yes, another Hispanic, Latino/a, or Spanish origin

Yes, Mexican, Mexican American, Chicano/a

Yes, Cuban

I choose not to answer.

What's your race? Select all that apply.

American Indian or Alaska Native

Asian:

Asian Indian

Japanese

Other Asian

Chinese

Korean

Filipino

Vietnamese

Black or African American

Native Hawaiian and Pacific Islander:

Guamanian or Chamorro

Samoan

Native Hawaiian

Other Pacific Islander

White

I choose not to answer

What is your gender? Select one.

Woman

Non-binary

Man

I use a different term: _____

I choose not to answer

Which of the following best represents how you think of yourself? Select one.

Lesbian or gay

Straight, that is, not gay or lesbian

Bisexual

I use a different term: _____

I don't know

I choose not to answer

Select one if you want us to send you information in a language other than English.

English

Spanish

Tagalog

Chinese

Select one if you want us to send you information in an accessible format.

Large print

Braille

Audio CD

Other: _____

Contact CareAdvantage at **1-866-880-0606** if you need information in an accessible format other than what's listed above.

Office hours are Monday – Sunday 8:00 am to 8:00 pm. (TTY: **1-800-735-2929** or **7-1-1**).

Current Primary Care Provider, clinic or health center:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature _____

National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]