HealthPlan OF SAN MATEO
CareAdvantage
Dual Eligible Special Needs Plan (D-SNP)

ENROLLMENT FORM

OMB No. 0938-1378 (Expires 7/31/2024)

CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a Dual Special Needs 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. If you want to join during fall open enrollment (October 15–December 7), Health Plan of San Mateo (HPSM) must get your completed form by December 7. You can return this form to HPSM in three ways:

Mail:
Health Plan of San Mateo
C/O Marketing
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:
650-829-2015

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**)

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.

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

First Name | Last Name | Middle Initial *(optional)*

Date of Birth (MM/DD/YYYY) | Sex ☐ Male ☐ Female | Phone #

Home Address *(where you live)* | City | State | Zip | County *(optional)*

Mailing Address *(if different from home address)* | City | State | Zip | County *(optional)*

Email Address | Emergency Contact | Emergency Contact Phone #

Medicare # (This information can be found on the front of your card.)

Medi-Cal # (*This information can be found on the front of your card.)*

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

Representative's name (please print) | Representative's signature

Representative's address | City | State | Zip | County *(optional)*

Relationship to enrollee | Representative's phone # | Today's date

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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

What is your preferred language?

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Chinese
- ☐ Russian
- ☐ Other (please list):

Do you want your information sent to you in your preferred language? ☐ Yes ☐ No

Do you need your information sent to you in another accessible format? If yes, select one:

- ☐ 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:

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Attestation Form

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact CareAdvantage Unit at **1-866-880-0606** (toll free) or **650-616-2174** TTY users can use the California Relay Service (CSR) at **1-800-735-2929** or dial **7-1-1** to see if you are eligible to enroll. We are open Monday through Sunday, 8:00 a.m. to 8:00 p.m.