CareSource
MID ROGUE HEALTH PLAN
www.caresourcehealthplans.com

ENROLLMENT FORM

740 SE 7th St., Grants Pass, OR 97526
Member Services: 541.471.4106
Toll-free: 1.888.460.0185
TTY: 1.800.735.2900

Please check which plan you want to enroll in:

☐ **Gold** (HMO) $59/month (Josephine County*)
☐ **Gold** (HMO) $79/month (Jackson County**)
☐ **Silver** (HMO) $23/month
☐ **Platinum** (HMO-POS) $113/month
☐ **Diamond** (PPO) $91/month
☐ **Gold Plus Rx** (HMO) $114.60/mo. (Josephine County*)
☐ **Gold Plus Rx** (HMO) $134.70/mo. (Jackson County**)
☐ **Silver Plus Rx** (HMO) $54.60/month
☐ **Platinum Plus Rx** (HMO-POS) $150.70/month
☐ **Diamond Plus Rx** (PPO) $142.60/month

* Josephine and Curry Counties, Rogue River and Gold Hill (Jackson County), Glendale and Azalea (Douglas County)
** Jackson County excluding Rogue River and Gold Hill

LAST Name ____________ FIRST Name ____________ MIDDLE Initial ____

Birth Date __ __ / __ __ / __ __ __ __ Sex __ M __ F Home Phone (______) ____________

Permanent Residence Street Address ____________

City ____________ State ______ ZIP ______

Mailing Address (if different) Street or PO Box ____________

City ____________ State ______ ZIP ______

E-mail Address ____________

Please provide your Medicare insurance information

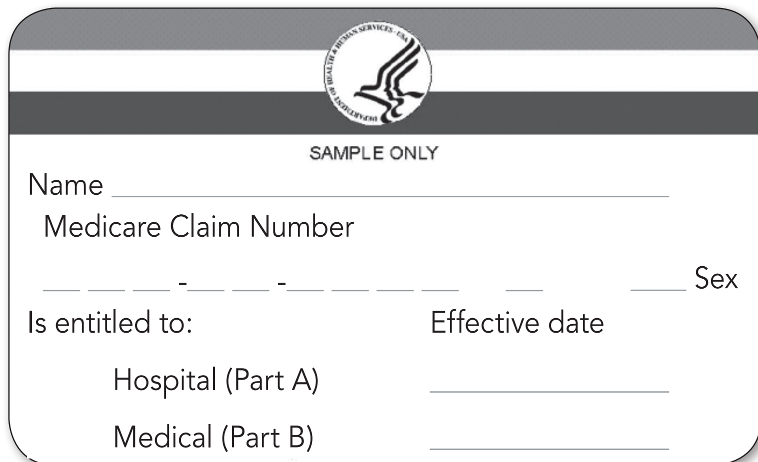
Please take out your Medicare card to complete this section.

- 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 ____________
Medicare Claim Number
__ __ __ - __ __ - __ __ __ __ __ __ Sex
Is entitled to: Effective date
Hospital (Part A) ______
Medical (Part B) ______

Paying your premium

You can pay your monthly plan premium by mail or by a monthly **electronic funds transfer (EFT)**. You can also choose to pay your premium by automatic deduction from your **Social Security benefit check** each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov.prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select a premium payment option: (If you don't select a payment option, you will get a bill each month.)

___ **Get a bill** (___ monthly ___ quarterly ___ semi-annually ___ annually)

___ **EFT** (please complete the authorization form on page 6 of this booklet)

___ **Automatic deduction from your monthly Social Security check** (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions

1. **Do you have End Stage Renal Disease (ESRD)?** ____ Yes ____ No

   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.

2. 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 CareSource? ____ Yes ____ No

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

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

3. **Are you a resident in a long-term care facility, such as a nursing home?** ____ Yes ____ No

   If "yes," please provide the following information:

   Name of Institution ______________________________

   Address ______________________ Phone (______) ______________

4. **Are you enrolled in your State Medicaid program?** ____ Yes ____ No

   If "yes," please provide your Medicaid number ______________________

5. **Do you or your spouse work?** ____ Yes ____ No

Please provide the name of your chosen Primary Care Physician (PCP), clinic or health center:

Please check below if you would prefer us to send you information in another format

____ Large print

Please contact CareSource at 1-888-460-0185. If you need information in another format or language than what is listed above. Our office hours are Monday – Friday, 8:00 a.m. – 5:00 p.m. TTY users should call 1-800-735-2900.

Please read this important information

If you currently have health coverage from an employer or union, joining CareSource could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CareSource. 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.

Please read and sign on page 4

By completing this enrollment application, I agree to the following:

CareSource is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. 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. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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: November 15 – December 31 of every year), or under certain special circumstances.

CareSource serves a specific service area. If I move out of the area that CareSource serves, 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 CareSource, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from CareSource 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 CareSource coverage begins, I must get all of my health care from CareSource, except for emergency or urgently needed services or out-of-area dialysis services.

Diamond plan members: I understand that beginning on the date CareSource coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services

or out-of-area dialysis services. If medically necessary, CareSource provides refunds for all covered benefits, even if I get services out of network.

Services authorized by CareSource and other services contained in my CareSource Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR CareSource 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 CareSource, he/she may be paid based on my enrollment in CareSource.

Release of Information

By joining this Medicare health plan, I acknowledge that CareSource will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that CareSource 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 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 by CareSource or by Medicare.

Your Signature ______________________ **Today's Date** ____________

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

Name ______________________ Relationship to Enrollee ______________________

Address ______________________ Phone (______) ______________________

CareSource will be contacting you to discuss your enrollment experience and verify the information in this enrollment packet.

Office Use Only:

Staff member/agent/broker(if assisted with enrollment):

____

Plan ID # ______________________ ☐ A ☐ B ☐ C ☐ D

Effective Date of Coverage ______________________

____ Not Eligible

ICEP/IEP ______

OEP ______

AEP ______

SEP (type) ______

Enrollment period determination

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't *add* or *drop* your prescription drug coverage (i.e. if you have Medicare prescription drug coverage you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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 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 ____________________ (date).

____ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

____ I get extra help paying for Medicare prescription drug coverage.

____ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on ____________________ (date).

____ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on ____________________ (date).

____ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home). I moved/will move into/out of the facility on ____________________ (date).

____ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on ____________________ (date).

____ I recently left a PACE program on ____________________ (date).

____ I am leaving employer or union coverage on ____________________ (date).

____ None of these statements apply to me.*

* **Please contact CareSource at 1-888-460-0185 (TTY users should call 1-800-735-2900) to see if you are eligible to enroll. We are open Monday – Friday, 8:00 a.m. – 5:00 p.m.**