Member Name:_____ Medical Assistance ID #:_____

HealthPartners® MSHO (HMO SNP) Enrollment Form

HealthPartners Enrollment Telephone Numbers
952-883-5050 or 877-713-8215. TTY for the hearing impaired at 711. The call is free.

From **Oct. 1 through Dec. 7**, we take calls from 8 a.m. to 6 p.m. CT, **Monday through Saturday**. From **Dec. 8 through Sept. 30**, call us 8 a.m. to 6 p.m. CT, **Monday through Friday** to speak with a representative. On Federal holidays and days we're closed, you can leave a message and we'll get back to you within one business day.

HealthPartners Member Services Telephone Numbers for Medical and Prescription Drug questions
952-967-7029 or 888-820-4285. TTY for the hearing impaired at 711. The call is free.

From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative. From **April 1 to Sept. 30**, call us 8 a.m. to 8 p.m. CT **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

Return the completed form to:

HealthPartners
Attn: MSHO Sales
Mailstop: 21102A
P.O. Box 1309
Minneapolis, MN 55440-1309
Fax: 952-853-8718

Office Use Only:

Date: _____

Name of Authorized Sales Person _____

HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance Program (Medicaid) to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.

Member Name:_____ Medical Assistance ID #:_____

HealthPartners® MSHO (HMO SNP) Enrollment Request Form

To join HealthPartners MSHO, you must have **Medicare Part A**, **Medicare Part B**, **and Medical Assistance (Medicaid)**, **and** be age 65 or over and live in HealthPartners MSHO's service area.

Section 1. Tell us about yourself:

1	**Name: (first, middle, last)**	
2	**Date of birth:** (__ __/__ __/__ __ __ __) **M M D D Y Y Y Y**	**Sex:** ☐ Female ☐ Male
3	**Phone number:** (_____) _____ - _____	
4	**Address where you live (P.O. Box is not allowed):** **City:** **State:** **ZIP code:** **County (Optional):**	
5	**Address where you get mail (if different from where you live):** **City:** **State:** **ZIP code:** **County (Optional):**	
6	**Do you live in a long-term care facility?** ☐ **Yes** ☐ No If yes, fill in the information below: **Name of the facility:** **Phone number:** (_____) _____ - _____	

Member Name:_____ Medical Assistance ID #:_____

Section 2. Tell us more about yourself:

Please tell us a little more about yourself. **You are not required to answer questions or give any information in this section. It's your choice to share this information with us.** We can't deny you coverage if you don't answer them.

7	**Do you want us to send you information in a language other than English?** □ **Yes** □ **No** If YES, circle language below. 01 Spanish 02 Hmong 03 Vietnamese 04 Khmer (Cambodian) 05 Lao 06 Russian 07 Somali 08 ASL (American Sign Language) 09 Amharic 10 Arabic 12 Oromo 14 Burmese 15 Cantonese 16 French 20 Korean 21 Karen 98 Other _____	
8	**Do you want us to send you information in an accessible format?** □ **Yes** □ **No** If YES, check format below. __ Braille __ Large print __ Audio Please contact HealthPartners at 952-883-5050 or 877-713-8215 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 6 p.m. CT, Monday through Saturday from Oct. 1 through Dec. 7, and 8 a.m. to 6 p.m. CT, Monday through Friday from Dec. 8 through Sept. 30. TTY users can call 711.	
9	**I want to get information electronically through HealthPartners secure online account**. □ **Yes** □ **No** You will receive information about signing up for an online account in your new member packet.	
10	**Do you work?** □ **Yes** □ **No**	**Does your spouse work?** □ **Yes** □ **No** □ Does not apply
11	**Name of the primary care clinic/care system you are choosing:** **Name of the dental clinic you are choosing:**	

Section 3. Tell us about your Medicare and Medical Assistance (Medicaid) coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) ID number as it appears on the front of your card.

12	**Medicare** **Number:** _____	**MHCP ID** **Number:** _____

Member Name:_____ Medical Assistance ID #:_____

Section 4. Tell us about 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.

13	**Do you have other health coverage?** ☐ **Yes** ☐ **No** If yes, fill in the information below:	
14	**Name of your plan (and employer, if applicable):**	**Group number:**
		ID number:
15	**Are you leaving employer or union coverage?** ☐ **Yes** ☐ **No** If yes, what is the coverage end date? _____	

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join HealthPartners MSHO. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Please read the information on page 5 and sign below.

When you sign this form, it means that you understand the information you read.

_____
Name of Applicant (Please print)

_____ _____
Signature Today's Date

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

_____ _____
Name (Print) Relationship to Enrollee

_____ _____
Address (Print) Telephone Number

When the form is completed, mail or fax it to HealthPartners. Our address and fax number are on the cover.

Member Name:_____ Medical Assistance ID #:_____

Information and Acknowledgement Statements

- My response to this form is voluntary. I understand that my enrollment in HealthPartners MSHO may be affected if I don't respond.
- I must keep Medicare Part A and Part B and Medical Assistance (Medicaid) to stay in HealthPartners MSHO.
- By joining HealthPartners MSHO, I acknowledge that the plan 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 collection of this information (see Privacy Act Statement below).
- On the date HealthPartners MSHO coverage begins, I must get my medical and prescription drug benefits from HealthPartners MSHO.
- Benefits and services HealthPartners MSHO provides and contained in my *Member Handbook* are covered. Neither Medicare nor HealthPartners MSHO will pay for benefits or services that are not covered.
- I understand that HealthPartners MSHO doesn't usually cover people while they're out of the country except under limited circumstances.
- If I am now getting Elderly Waiver services through the county, I am aware that my case manager may be replaced by a different county case manager or a health plan care coordinator.
- If I move, I need to tell my County Worker.
- I can choose to leave HealthPartners MSHO at certain times of the year. I understand that I will be enrolled in HealthPartners MSHO through the last day of the month. I understand that I will be automatically enrolled in the Minnesota Senior Care Plus (MSC+) plan, which will cover my Medical Assistance (Medicaid) benefits. If I ask in writing, I will be enrolled in my previous MSC+ plan.
- If I get a medical spenddown while enrolled in HealthPartners MSHO and do not pay it to the State, I will be disenrolled from HealthPartners MSHO.
- The information on this enrollment form is correct to the best of my knowledge. I understand that I will be disenrolled from HealthPartners MSHO if I intentionally give false information on this form.
- 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 they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid).

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 and 1860D-1 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.

Member Name: _____ Medical Assistance ID #: _____

HealthPartners® Minnesota Senior Health Options (MSHO) (HMO SNP): Tell us about your enrollment eligibility

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. Check all that apply. 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 applying during the Medicare Advantage plan annual enrollment period from Oct. 15 through Dec. 7 and want my enrollment effective Jan. 1.

☐ I am new to Medicare.

☐ I have both Medicare and Medical Assistance (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 recently had a change in my Medical Assistance (Medicaid) (newly got Medicaid or had a change in level of Medicaid assistance) on (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 (date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____.

☐ 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 am leaving employer or union coverage on (date) _____.

☐ 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 involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____.

☐ 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 (date) _____.

Member Name: _____ Medical Assistance ID #: _____

☐ I recently was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status on (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 apply to you or you're not sure, please contact HealthPartners at 952-883-5050 or 877-713-8215 (TTY users should call 711) to see if you're eligible to enroll. We are open 8 a.m. to 6 p.m. CT, Monday through Saturday from Oct. 1 through Dec. 7, and 8 a.m. to 6 p.m. CT, Monday through Friday from Dec. 8 through Sept. 30.

When the form is completed, return it to HealthPartners with your HealthPartners MSHO enrollment form.

HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance Program (Medicaid) to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.