



PrimeWest Senior Health Complete (HMO SNP)

Enrollment Form

PrimeWest Senior Health Complete **1-800-366-2906**

TTY for the hearing impaired **1-800-627-3529** or **711**

Calls to these numbers are free. Hours are 7 days a week, 8 a.m. – 8 p.m.

Return the completed form to PrimeWest Health

PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308
Fax: **1-320-335-5223**

A Coordinated Care plan with a Medicare Advantage contract and a contract with the Minnesota Medicaid program

Medicare_{Rx}
Prescription Drug Coverage

H2416_PW_2012_1007
DHS_Approved_10/21/2011/CMS_Approved_10/24/2011




Copies: Original – PrimeWest Health Pink – Member

Member Name: _____ Medical Assistance ID #: _____

PrimeWest Senior Health Complete (HMO SNP) Enrollment Form

To enroll in PrimeWest Senior Health Complete, please provide the following information:

1	Last Name:	First Name:	M.I.:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
2	Birth Date: (____/____/____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: ()	
3	Permanent Residence Street Address (PO Box is not allowed):			
	City:	County:		
	State:	Zip Code:		
4	Mailing Address (only if different from your Permanent Residence Street Address)			
	Street Address/PO Box:			
	City:	State:	Zip Code:	
5	Please Provide Your Medicare Insurance Information	 MEDICARE HEALTH INSURANCE		
	Please take out your Medicare card to complete this section.	<i>Sample only</i>		
	<ul style="list-style-type: none"> 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. 	Name: _____		
		Medicare Claim Number: _____ Sex: _____		
		_____ - _____ - _____		
		Is Entitled To: _____ Effective Date: _____		
		HOSPITAL (Part A) _____		
		MEDICAL (Part B) _____		
6	Please provide your Medical Assistance ID number (it is on your Minnesota Health Care Programs card):			
7	Are you a resident in a long-term care facility such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If "Yes," please provide the following information:			
	Name of facility: _____		Phone number of facility: _____	
8	Primary care clinic you are choosing:		Primary care clinic number found in <i>Primary Care Network Listing</i> :	
9	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," circle correct language:			
	01 Spanish	02 Hmong	03 Vietnamese	04 Khmer (Cambodian) 05 Lao 06 Russian
	07 Somali	08 ASL (American Sign Language)	10 Arabic	11 Serbo-Croatian/Bosnian
	12 Oromo	98 Other _____		

10

Please read and answer these important questions:

1. Do you have End Stage Renal Disease? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please **attach a note or records** from your health care provider showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits.

Will you have other prescription drug coverage in addition to PrimeWest Senior Health Complete?

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. Do you or your spouse have health insurance, including through a previous or current employer?

Yes No If "Yes," employer/insurer name: _____

Policyholder's name: _____ Policy #: _____



Please Read This Important Information

If you currently have health coverage from an employer or union, joining PrimeWest Senior Health Complete could affect your employer or union health benefits. You could lose your employer or union health coverage if you join PrimeWest Senior Health Complete. 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 3

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

- PrimeWest Senior Health Complete is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B.
- PrimeWest Senior Health Complete will be providing coverage for my care covered by Medicare and Medical Assistance.
- I can be in only one (1) 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 the plan of any prescription drug coverage that I have or may get in the future.
- To be enrolled and stay enrolled in PrimeWest Senior Health Complete, I must meet all the following criteria:
 - Be at least 65
 - Be eligible for Medical Assistance
 - Have Medicare Parts A and B
 - Live in the PrimeWest Senior Health Complete service area

If any of this changes, I will notify PrimeWest Senior Health Complete so I can disenroll and find a new plan.

- I can choose to leave PrimeWest Senior Health Complete at any time. I understand that I will be enrolled in PrimeWest Senior Health Complete 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 benefits. If I request in writing, I will be enrolled in my previous MSC+ plan.
- Once I am a member of PrimeWest Senior Health Complete, I have the right to Appeal plan decisions about payment or services if I disagree.

Member Name: _____ Medical Assistance ID #: _____

- I will read the *Evidence of Coverage* from PrimeWest Senior Health Complete 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 PrimeWest Senior Health Complete coverage begins, I must get all of my health care from PrimeWest Senior Health Complete network providers, except for emergency or urgently needed services, out-of-area or out-of-network dialysis services, **open access** services, or any other services previously authorized. Services authorized by PrimeWest Senior Health Complete and other services contained in my PrimeWest Senior Health Complete *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR PRIMEWEST SENIOR HEALTH COMPLETE 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 PrimeWest Senior Health Complete, he/she may be paid based on my enrollment in PrimeWest Senior Health Complete.
- If I obtain a medical spenddown while enrolled in PrimeWest Senior Health Complete and do not pay it to DHS, I will be disenrolled from PrimeWest Senior Health Complete.
- 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.

Release of information:

By joining PrimeWest Senior Health Complete, I acknowledge that:

- PrimeWest Senior Health Complete will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
- PrimeWest Senior Health Complete will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.
- By enrolling in PrimeWest Senior Health Complete, I authorize the State to give information about my Medicare and Medical Assistance status and the information on this form to its representatives, the county where I live now, and to PrimeWest Health.
- 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 by State law to complete this enrollment form, and
2. Documentation of this authority is available upon request from Medicare.

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)

()

Phone #

Office Use Only

Date: _____
 Name of Authorized Sales Person: _____
 Effective Date of Enrollment: _____
 LIS Copay Level: _____
 LIS Copay Eff Date: _____
 Approved by: _____

Instructions for filling out the PrimeWest Senior Health Complete Enrollment Form

Please print as neatly as possible.

Please fill in the following information by numbered line on your enrollment form.

1	Name	Write your name (last name, first name, middle initial).
2	Birth Date	Write in the month, day, and year you were born.
	Sex	Check the box indicating if you are male or female.
	Phone Number	Write in the telephone number where you can be reached during the day.
3	Permanent Residence Street Address	Write in the permanent address where you live, including street address, city, county, state, and zip code (no PO boxes).
4	Mailing Address	Write in the address where you receive your mail, if different from your permanent street address.
5	Medicare Number	Take out your Medicare card to complete this section. Write your Medicare number as it appears on your red, white, and blue card (not your Social Security card).
	Effective Date Hospital (Part A)	Write in the effective date for Hospital (Part A) as it appears on your card.
	Effective Date Medical (Part B)	Write in the effective date for Medical (Part B) as it appears on your card.
6	Medical Assistance ID Number	Write in your Medical Assistance number.
7	Are you a resident in a long-term care facility?	If you now live in a long-term care facility, such as a nursing home or ICF-DD, check "Yes" and write in the name, address, and phone number. If you do not, check "No."
8	Primary care clinic	Go to the health plan's <i>Primary Care Network Listing</i> in your information packet. Write in the primary care clinic that you choose.
	Primary care clinic #	Write the code of the primary care clinic that you choose, located in the <i>Primary Care Network Listing</i> .
9	Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," circle the code of the language needed on the list.
10	1. End Stage Renal Disease	1. Check "Yes" or "No."
	2. Other prescription drug coverage	2. If you answered "Yes" to this question, please fill out the name of the other coverage, the ID number, and Group number.
	3. Other health insurance	3. If you answered "Yes" to this question, please fill out the employer/insurer name, policyholder's name, and policy number.

Page 3 should be signed and filled out by you or your authorized representative. When the form is completed, mail or fax it to PrimeWest Health. Our address and fax number are on the cover.

PrimeWest Health

Member Services

7 days a week, 8 a.m. – 8 p.m.

1-800-366-2906 (toll free)

Attention. If you want free help translating this information, call the above number.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات،
تواصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປ ຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທຫາຕາມເລກໂທທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

ADDRESS

PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308

WEBSITE

www.primewest.org

This information is available in other forms to people with disabilities by calling:

TOLL FREE

1-800-366-2906

TOLL FREE MINNESOTA RELAY

TTY, Voice, ASCII, or Hearing Carry Over:
1-800-627-3529 or 711

TOLL FREE SPEECH-TO-SPEECH RELAY SERVICE

1-877-627-3848

PrimeWest Health will enroll all eligible people who select or are assigned to PrimeWest Health without regard to physical or mental condition, health status, need for health care services, claims experience, medical history, genetic information, disability, marital status, age, gender, sexual orientation, national origin, race, ethnicity, color, religion, political beliefs, or geographic location. PrimeWest Health will not use any policy or practice that discriminates based on such.

American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older, this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.