

## Special Needs BasicCare (SNBC) Enrollment Form - EXPANSION

Last name:	First name:	MI	Birthdate:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
County you live in:	Social Security number (optional):	Home phone: ( )		
Street address:	City:	State:	Zip Code:	
Mailing address (if different from where you live):	City:	State:	Zip Code:	
Case number:	Medical Assistance ID #:			
Do you need an interpreter? <input type="checkbox"/> NO <input type="checkbox"/> YES – check one of the boxes below <input type="checkbox"/> Spanish (01) <input type="checkbox"/> Hmong (02) <input type="checkbox"/> Vietnamese (03) <input type="checkbox"/> Khmer (Cambodian) (04) <input type="checkbox"/> Lao (05) <input type="checkbox"/> Russian (06) <input type="checkbox"/> Somali (07) <input type="checkbox"/> American Sign Language (08) <input type="checkbox"/> Arabic (10) <input type="checkbox"/> Serbo-Croatian/Bosnian (11) <input type="checkbox"/> Oromo (12) <input type="checkbox"/> (98) Other, explain _____				
Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Some individuals may have other medical coverage, including other private insurance. Do you have other medical coverage? <input type="checkbox"/> NO <input type="checkbox"/> YES – provide information about your other coverage below:  Insurance company name: _____ Group # for this coverage: _____ Policyholder's name: _____ Policy/ID #: _____				
Do you have Medicare? <input type="checkbox"/> NO <input type="checkbox"/> YES – provide information about your Medicare below: Medicare Claim #: _____ Part A start date: _____ Part B start date: _____				
<b>CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE</b>				
You do not have to join SNBC. You can keep getting your health care coverage from Medical Assistance (Medicaid) fee-for-service. Remember, if you do join SNBC and you do not like the program, you may drop out and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month.				
Primary care clinic you are choosing:			Primary care clinic number found in <i>Primary Care Network Listing</i> :	

**Please read and sign the back of this form.**

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

PrimeWest Health will be providing coverage for my Medical Assistance (Medicaid)-covered health care.
Once I am a member of PrimeWest Health, I have the right to Appeal any services that are being denied, reduced, or stopped, or if PrimeWest Health is denying payment for services.
I will be notified of the date my coverage will start.
If I do not receive all of my covered health care from PrimeWest Health's network providers, then PrimeWest Health will not pay for services, except in an emergency or for urgently needed services.
I will read the <i>Evidence of Coverage</i> I get from PrimeWest Health. It will have the rules I must follow and more information about covered services authorized by my plan. Services authorized by PrimeWest Health and other services contained in PrimeWest Health's <i>Evidence of Coverage</i> will be covered. Without authorization, <b>MY PLAN WILL NOT PAY FOR THE SERVICES.</b>
PrimeWest Health benefits <b>cannot</b> be canceled because I get sick or use health care services.
I can choose to leave PrimeWest Health and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month.
I must choose a primary care clinic and my health care services will be coordinated through PrimeWest Health.
To be enrolled and stay enrolled in SNBC, I must: <ul style="list-style-type: none"><li>• Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT)</li><li>• Be under age 65 at the time of enrollment</li><li>• Be eligible for Medical Assistance (Medicaid)</li><li>• Have no Medicare OR Medicare Parts A <b>and</b> B</li><li>• Live in a county served by PrimeWest Health</li></ul>
If any of these things changes, I will notify my county worker and my health plan so I can disenroll.

<b>By enrolling in PrimeWest Health, I authorize</b> the State to give information about my Medical Assistance (Medicaid) eligibility and the information on this form to its representatives, the county where I live, and PrimeWest Health.
The information on this form is correct to the best of my knowledge.

**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 form means that I have read and understand the contents of this form. 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 form on my behalf, and 2) I will provide documentation of this authority upon request by the State or PrimeWest Health.**

Signature of enrollee or authorized representative:		Date:
<b>If you are the authorized representative, you must sign above and provide the following information:</b>		
Name (please print):	Relationship to enrollee:	Phone: (    )
Address:		
City:	State:	Zip Code:

Please return this form by mail or fax to:      Mail: Attn: Member Services  
PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

Fax: 1-320-335-5223

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

TOLL FREE

Member Services: 1-866-431-0801

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

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## Member Services

**1-866-431-0801**

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، فاتصل 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 ໂທສຕາມເລກໂທສທີ່ຢູ່ຂ້າງເທິງນີ້.

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.

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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.