PrimeWest HEALTH

Special Needs BasicCare (SNBC) Enrollment Form

Special Needs BasicCare Member Services Telephone Numbers

1-866-431-0801
TTY for the hearing impaired at **1-800-627-3529** or **711**
Monday – Friday, 8 a.m. – 8 p.m.
The call is free.

You can speak to someone about getting this information for free in other languages. Call **1-866-431-0801**. TTY users should call **1-800-627-3529** or **711**, Monday – Friday, 8 a.m. – 8 p.m. The call is free.

Return the completed form, pages 1 – 2, to:
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308
Fax: **1-320-335-5223**

PrimeWest Health service area: Beltrami, Big Stone, Clearwater, Douglas, Grant, Hubbard, McLeod, Meeker, Pipestone, Pope, Renville, Stevens, and Traverse counties in Minnesota

PrimeWest HEALTH

Special Needs BasicCare Enrollment Form

Last name	First name	MI (optional)	Birth date (____/____/_____) MM / DD / YYYY	Gender ❑ M ❑ F
County you live in	Social Security number (optional)		Phone number (_____) _____ – _____	
Street address (where you live)	City		State	Zip code
Mailing address (if different from where you live)	City		State	Zip code
Email address (optional)				
Medical Assistance ID number (PMI)	Case number		Are you pregnant? ❑ YES ❑ NO	

Do you need an interpreter? ❑ YES ❑ NO If Yes, check one of the boxes below

❑ Spanish (01) ❑ Hmong (02) ❑ Vietnamese (03) ❑ Khmer Cambodian (04) ❑ Lao (05)
❑ Russian (06) ❑ Somali (07) ❑ ASL (American Sign Language) (08) ❑ Amharic (09) ❑ Arabic (10)
❑ Oromo (12) ❑ Burmese (14) ❑ Cantonese (15) ❑ French (16) ❑ Korean (20)
❑ Karen (21) ❑ Other (98), explain _____

Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver? ❑ YES ❑ NO

Do you have Medicare coverage? ❑ YES ❑ NO If Yes, complete the information below

Medicare number: _____

Hospital (Part A) Begin Date: _____ Medical (Part B) Begin Date: _____

Some individuals may have other medical coverage, including other private insurance.
Do you have other medical coverage? ❑ YES ❑ NO If Yes, fill in the information below

Insurance company name: _____

Policyholder's name: _____ Group number: _____

Policy/ID number: _____ Is this insurance through an employer? ❑ YES ❑ NO

CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to drop out and change back to Medical Assistance (Medicaid) fee-for-service effective the next available month.

Please read and sign the bottom of this form.

Under SNBC, I understand that:

PrimeWest Health will be providing my health care covered by Medical Assistance (Medicaid).
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.
On the date **PrimeWest Health** coverage begins, I must get my health care from **PrimeWest Health** doctors and other providers, except for emergency or urgently needed care, **open access services**, out-of-area dialysis, or if I get **PrimeWest Health** approval to see other providers in some circumstances.
I will read the ***Member Handbook*** from **PrimeWest Health**. It will have the rules I must follow and more information about the services my plan covers. Services contained in **PrimeWest Health's *Member Handbook*** will be covered.
Some services require authorization from **PrimeWest Health**. Without authorization, **PrimeWest Health** will not pay for these services.
My **PrimeWest Health** benefits **cannot** 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 understand that I will be enrolled in **PrimeWest Health** through the last day of the month.
My health care services will be coordinated through **PrimeWest Health**.
To be enrolled and stay enrolled in **PrimeWest Health**, I must: • Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) or be enrolled in the Developmental Disability waiver • Be at least 18 years old and under 65 years old • Be eligible for Medical Assistance (Medicaid) without a medical spenddown • Either have no Medicare, **OR** have **both** Medicare Parts A **and** B • Live in a county serviced by **PrimeWest Health** If this changes, I will notify my county worker and **PrimeWest Health** so I can disenroll.
If I get a medical spenddown while enrolled in SNBC and **do not pay it to DHS**, I will be disenrolled from **PrimeWest Health**.
If I am on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in PrimeWest Health, I authorize:

The sharing of information about my Medical Assistance (Medicaid) eligibility status and the information on this form among the State, its representatives, the county where I live, and **PrimeWest Health**.
The information on this enrollment 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 the form. 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 on my behalf, and 2) documentation of this authority is available upon request by the State or PrimeWest Health.

Signature of enrollee or authorized representative:	Date:

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

Name (print):	Relationship to enrollee:	Phone number:
Street address, city, state, zip:		

This page 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.

1-866-431-0801 (toll free); TTY **1-800-627-3529** or **711**

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီ၊်ဂံ၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. PrimeWest Health does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: PrimeWest Health provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 (toll free) or TTY 1-800-627-3529 or 711.**

Language Assistance Services: PrimeWest Health provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 (toll free) or TTY 1-800-627-3529 or 711.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

PrimeWest Health Complaint Notice

You have the right to file a complaint with PrimeWest Health if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Rebecca Fuller
Civil Rights Coordinator
PrimeWest Health
3905 Dakota St
Alexandria, MN 56308
Toll Free: 1-866-431-0801
TTY: 1-800-627-3529 or 711
Fax: 1-320-762-8750
Email: rebecca.fuller@primewest.org

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders 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.