Health Plan of San Joaquin | Mountain Valley Health Plan

Advantage D-SNP

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

OMB No. 0938-1378, Expires: 02/28/2029

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Health Plan of San Joaquin/Mountain Valley Health Plan
Advantage D-SNP (HMO)
7751 South Manthey Road
French Camp, CA 95231

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at **1-888-361-7526**. TTY users can call **711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Health Plan of San Joaquin/ Mountain Valley Health Plan Advantage D-SNP al **1-888-361-7526 TTY 711** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO) - $0 per month

FIRST name:	LAST name:	[Optional: Middle Initial]:

Birth date (MM/DD/YYYY) (/ /)	Sex: ☐ Male	☐ Female	Phone Number:

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street Address:	City:	State:	ZIP Code:

Your Medicare Information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP? ☐ Yes ☐ No

Name of other coverage: Member number for this coverage:

Group number for this coverage:

Dual Special Needs (HMO D-SNP) plans are for those who qualify for Medicare and Medicaid. By enrolling in this plan, you understand that you must remain enrolled in your state Medicaid program to remain eligible for this plan.

1) Are you enrolled in your state Medicaid (Medi-Cal) program? ☐ Yes ☐ No

2) If "yes", please provide your Medicaid nine-digit Client Index Number (CIN):

3) Health Plan of San Joaquin/Mountain Valley Health Plan Member ID (if applicable):

IMPORTANT. Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.
- By joining this Medicare Advantage, I acknowledge that Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP 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 the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP coverage begins, I must get all of my medical and prescription drug benefits from Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Benefits and services provided by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP and contained in my Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will pay for benefits or services that are not covered.

- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at 1-888-361-7526 if you need information in an accessible format other than what's listed above. Our office hours are Monday - Friday, 8:00 a.m to 8:00 p.m. TTY users can call 711.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

Consent to contact:

I, _____(enrollees name), consent to Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP, directly or through third parties acting on its behalf, contacting me about my health care, health insurance, health care options or services, other benefits, education, or any other related topic. I understand these messages may be sent to me by a variety of methods, including email, text messages, or phone calls to my cell phone, including automated calls or recorded messages. I understand I can revoke this consent at any time by contacting Health Plan of San Joaquin/ Mountain Valley Health Plan Advantage D-SNP Customer Service at 1-888-361-7526, Monday - Friday, 8:00 a.m. to 8:00 p.m. TTY users can call 711.

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Provider/Pharmacy Directory
☐ Summary of Benefits ☐ List of covered drugs

E-mail address:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP is an HMO with a Medicare and a Medi-Cal contract. Enrollment in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP depends on contract renewal.

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 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.