HealthPartners®

HealthPartners® Classic MSHO Plan (HMO SNP) Enrollment Form

HealthPartners Enrollment Telephone Numbers
952-883-5050 or 1-877-713-8215. TTY for the hearing impaired at 952-883-6060 or 1-800-443-0156.
Medical and Prescription Drug questions: Seven days a week, 8 a.m. to 8 p.m.

HealthPartners Member Services Telephone Numbers
952-967-7029 or 1-888-820-4285. TTY for the hearing impaired at 952-883-6060 or 1-800-443-0156.
Medical and Prescription Drug questions: Seven days a week, 8 a.m. to 8 p.m.

This plan is offered and administered by HealthPartners. HealthPartners Classic MSHO Plan is a Special Needs Plan (HMO SNP) with a Medicare contract.

Attention. If you want free help translating this information, call HealthPartners® at 952-967-7029 or 1-888-820-4285.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم HealthPartners® 952-967-7029 أو 1-888-820-4285.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ HealthPartners® 952-967-7029 ឬ 1-888-820-4285 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite HealthPartners® 952-967-7029 ili 1-888-820-4285.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu HealthPartners® 952-967-7029 lossis 1-888-820-4285.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ HealthPartners® 952-967-7029 ຫຼື 1-888-820-4285.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu HealthPartners® 952-967-7160 ykn 1-888-820-4285.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните HealthPartners® 952-967-7029 или 1-888-820-4285.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac HealthPartners® 952-967-7159 ama 1-888-820-4285.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame a HealthPartners® al 952-967-7050 o al 1-888-820-4285.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi HealthPartners® 952-967-7029 hoặc 1-888-820-4285.

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This information is available in other forms to people with disabilities by calling 952-967-7029 (voice) or 1-888-820-4285 (toll free voice), 952-883-6060 (TTY), 1-800-443-0156 (toll free TTY), 711, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech).

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 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.

white copy – health plan *pink copy – enrollee*

HealthPartners®
8170 33rd Ave. South
Bloomington, MN 55425
Fax 952-853-8746

Office Use Only:
Date: _____
Name of Authorized Sales Person _____

HealthPartners® Classic MSHO Plan (HMO SNP) Enrollment Form

1	Last Name:	First Name:	M.I.	☐ Mr. ☐ Mrs. ☐ Ms.
2	Birth Date: (___/___/_____) MM DD YYYY	Sex: ☐ Male ☐ Female	Home Phone Number:	Alternate Phone Number:
3	Permanent Residence Street Address (P.O. Box is not allowed):			
	City:	State:	Zip code:	
4	Full Name (if different from applicant): Mailing Address (only if different from your Permanent Residence Street Address): Street Address/ P.O. Box:	City:	State:	Zip Code:
5	County of Residence:			
6	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE Name: _____ __ Medicare Claim Number Sex __ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A) _____** **MEDICAL (Part B) _____**		
7	Please provide your Medical Assistance ID number (it is on your Minnesota Health Care Programs card):			
8	Are you a resident in a long-term care facility such as a nursing home or ICF-MR? ☐ Yes ☐ No If "Yes," please provide the following information: Name of institution: Primary Phone Number of Institution:			
9	Primary Care Clinic you are choosing: Primary Dental Clinic you are choosing:	Primary Care Clinic # found in Primary Clinic Network Listing: Primary Dental Clinic #:		
10	Race (optional) ☐ Asian ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Pacific Islander or Native Hawaiian			

11	Do you need an interpreter? ☐ Yes ☐ No If YES, circle correct language below.					
	01 Spanish 07 Somali	02 Hmong 08 ASL American Sign Language	03 Vietnamese 10 Arabic	04 Cambodian 11 Bosnian-Serbo-Croatian	05 Laotian 12 Oromiffa	06 Russian 98 Other _____
12	**Please read and answer these important questions:** 1. Do you have End Stage Renal Disease? ☐ Yes ☐ No If you answered "Yes" to this question and you don't need regular dialysis any more or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant. 2. Do you or your spouse have health insurance through a previous or current employer? ☐ Yes ☐ No If "Yes," employer name: _____ Policy holder's name: _____ Policy #:_____ 3. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage or VA benefits. Will you have other prescription drug coverage in addition to HealthPartners? ☐ 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: _____					

STOP! Please read this important information.

If you currently have health coverage from an employer or union, joining HealthPartners® Classic MSHO Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthPartners® Classic MSHO Plan. 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 the information on the back of Page 3 before you sign below.

Release of information: By joining HealthPartners, I acknowledge that:

- HealthPartners will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
- HealthPartners will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- By enrolling in HealthPartners, 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 HealthPartners.
- 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 HealthPartners.

I understand that my signature (or the signature of the person authorized to act on 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 by HealthPartners or by 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)

Telephone Number

Please read and sign on page 3.

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

- HealthPartners® Classic MSHO Plan is a Medicare Advantage plan and has a contract with the Federal government.
- HealthPartners® Classic MSHO Plan 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 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 HealthPartners® Classic MSHO Plan, I must:
  - be at least 65;
  - be eligible for Medical Assistance;
  - have Medicare Parts A and B; and
  - live in the HealthPartners® Classic MSHO Plan service area.

  If any of this changes, I will notify HealthPartners so I can disenroll and find a new plan.
- I can choose to leave HealthPartners at any time. I understand that I will be enrolled in HealthPartners® Classic MSHO Plan 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 HealthPartners, I have the right to appeal plan decisions about payment and services if I disagree.
- I will read the ***Certificate of Coverage*** from HealthPartners when I receive 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 HealthPartners® Classic MSHO Plan coverage begins, I must get all of my Medicare-covered health care from HealthPartners network providers. If I don't, NEITHER MEDICARE NOR HEALTHPARTNERS WILL PAY FOR THE SERVICES. Exceptions to this rule are emergency care, urgently needed services, **open access** services, out-of-network dialysis services or any other services previously authorized. Services authorized by HealthPartners and other services contained in my ***Certificate of Coverage*** will be covered.
- I understand that if I am receiving assistance from a sales agent, broker or other individual employed by or contracted with HealthPartners, he/she may be paid based on my enrollment in HealthPartners® Classic MSHO Plan.
- If I obtain a medical spend down while enrolled in HealthPartners® Classic MSHO Plan and do not pay it to DHS, I will be disenrolled from HealthPartners® Classic MSHO Plan.
- 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.

Instructions

For filling out the HealthPartners® Classic MSHO Plan Enrollment Form

Please print as neatly as possible.
Please fill in the following information by numbered line on your enrollment form.

1	Name:	Write you name (last name, first name, middle initial)
2	Birth date: Sex: Phone number: Alternate phone number:	Write the day, month, and year you were born. Check the box indicating if you are male or female. Write the telephone number where you can be reached during the day.
3	Permanent Street address:	Write in the permanent address where you live, including street address, city, state and zip code (no P.O. boxes).
4	Mailing address:	Write full name of person who receives mail, if different from applicant. Write in the address where you receive your mail, if different from your permanent street address.
5	County of Residence	Write in the county where you live.
6	Medicare Number Effective Hospital (Part A): Effective Medical (Part B):	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). Write in the effective date for Hospital (Part A) as it appears on your card. Write in the effective date for Medical (Part B) as it appears on your card.
7	Medical Assistance	Write in your Medical Assistance number.
8	Are you a resident of a long-term care facility?	If you now live in a long-tern care facility, such as a nursing home or ICF-MR, check “Yes” and write in the name, address and phone number. If you do not, check “No.”
9	Primary Care Clinic Primary Dental Clinic Primary Care Clinic # Primary Dental Clinic #	Go to the health plan’s Primary Care Network Listing in your information packet. Write in the primary care clinic and dental clinic that you choose. Write the codes of the primary care clinic and dental clinic you choose which are located in the Primary Care Network Listing.
10	Race (Optional)	Check the box indicating your race.
11	Do you need an interpreter?	Check “Yes” or “No.” If you answer “Yes,” circle the code of the language need on the list.
12	1. End Stage Renal Disease 2. Health insurance through an employer 3. Other prescription drug coverage	Check “Yes” or “No.” If “Yes”, enter date dialysis started. If you answered “Yes” to this question, please fill out the employer name and policy number. If you answered “Yes” to this question, please fill out the name of the other coverage, the ID number, and Group number.

Page 3 should be signed and filled out by you or your authorized representative.