Medicare enrollment instructions

PriorityHealth

Thank you for choosing a Medicare plan from Priority Health. Please follow these helpful tips to avoid delays in processing your enrollment.

To enroll online visit *prioritymedicare.com*, the Provider/Pharmacy Directory and Formulary are also available here.

Enrollment form checklist

Make sure to:

☐ Choose an enrollment eligibility selection that applies to you on the first page.

☐ Check the appropriate box for the plan you wish to join.

☐ Choose a primary care provider (PCP), if applicable.
To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to *priorityhealth.com/findadoc* or call our Medicare Experts at the phone number listed below.

☐ Complete your Medicare Insurance information from your Medicare red, white and blue card or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.

☐ Choose how you would like to pay your premium and check the appropriate box.
There are three options available for paying your plan premium. You can choose to receive a monthly bill and pay by mail, Electronic Fund Transfer (EFT) from your bank account or automatic deduction from your monthly Social Security check.

☐ Sign and date the form.

Mail your completed enrollment form in the enclosed postage-paid envelope. Or, if you do not have a postage-paid envelope, you can send your completed enrollment form to Priority Health, MS 1175,1231 E. Beltline, Grand Rapids, MI 49525. If you have any questions or you would prefer that we send you information in another format, call our Medicare experts toll-free at 877.260.9806, from 8 a.m. – 8 p.m., seven days a week. TTY users should call 711.

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Medicare enrollment request form

Attestation of eligibility for an enrollment period
Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box for the statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information in incorrect, you may be disenrolled.

Continue >

Medicare enrollment request form

PriorityHealth

Choose one of the following:

☐ I am new to Medicare *(example: recently enrolled in Medicare Parts A and B).*

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ____/____/____.

☐ I am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).

☐ I am leaving employer or union coverage on (insert date) ____/____/____ *(example: retiring and losing coverage through an employer).*

☐ I am enrolled in a Medicare Advantage plan and want to make a one-time change during the Medicare Advantage Open Enrollment Period (Jan. 1 through March 31).

☐ I currently have Medicare Parts A and B due to disability and am turning 65 years of age.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____/____/____.

☐ I recently had a change in my Medicaid coverage on (insert date) ____/____/____
(example: newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

☐ I recently had a change in my extra help paying for Medicare prescription drug coverage on (insert date) ____/____/____ *(example: newly got extra help, had a change in the level of extra help, or lost extra help).*☐

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get extra help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____/____/____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____/____/____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ____/____/____.

☐ I recently was released from incarceration. I was released on (insert date) ____/____/____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____/____/____.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) ____/____/____.

☐ I recently left a PACE program on (insert date) ____/____/____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact Priority Health Medicare to see if you are eligible to enroll. Call toll-free 877.260.9806 (TTY users should call 711), 8 a.m. – 8 p.m., seven days a week.

White copy – Priority Health copy / Yellow copy – member copy

To enroll in Priority Health Medicare, please provide the following information

Please check which plan you want to enroll in:

☐ **Priority**Medicare Key℠ (HMO-POS) ☐ **Priority**Medicare Value℠ (HMO-POS) ☐ **Priority**Medicare℠ (HMO-POS)

☐ **Priority**Medicare Ideal℠ (PPO) ☐ **Priority**Medicare Merit℠ (PPO) ☐ **Priority**Medicare Select℠ (PPO)

Please choose the name of a doctor (primary care provider [PCP]), otherwise one will be assigned to you (if applicable). You may change your PCP at any time.

First name of doctor: _____ Last name of doctor: _____

Optional coverage

☐ I wish to enroll in the **Enhanced Vision, Dental and Hearing package**

This package is offered in addition to the standard dental benefit that's included in our plans. You're not required to enroll in the Enhanced Vision, Dental and Hearing package. You can choose to add this coverage any time within two months from your Priority Health Medicare Advantage plan effective date. For **Priority**Medicare Value, **Priority**Medicare Merit, **Priority**Medicare, or **Priority**Medicare Select plans, it's an additional monthly premium of $27.20. For **Priority**Medicare Key and **Priority**Medicare Ideal plans, it's an additional monthly premium of $32.

Last name	First name	M.I.

Birth date	Sex	Race (optional)
____/____/____ MM DD YYYY	☐ M ☐ F	☐ Hispanic/Latino ☐ Black/African American ☐ White/Caucasian ☐ Other ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander

Phone number that we may use to contact you:	Alternate number that we may use to contact you (optional):
☐ Landline (home phone) ☐ Mobile phone	☐ Landline (home phone) ☐ Mobile phone

Permanent residence street address (P.O. Box is not allowed)

City	County	State	ZIP code

Mailing street address (only if different from your permanent residence address)

City	County	State	ZIP code

Email address

Please include your email if you would like to opt-in to receiving plan documents and other health and plan information by email. You can unsubscribe at any time.

Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

– OR –

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is entitled to: Effective date:

HOSPITAL (Part A) ____/____/____

MEDICAL (Part B) ____/____/____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Agent use only

Referring agent: _____ Referring agent #: _____ Agent received application on: _____

Field Market Organization (FMO) name (if applicable): _____ FMO received application on (if applicable): _____

Scope of appointment completed:

☐ Yes. Date: _____ ☐ No. Reason: _____

Office use only

Subscriber ID: _____ Effective date of coverage: _____

ICEP / IEP / AEP / SEP/ OEP (type): _____ PBP ID: _____

Not eligible: _____ Processing rep: _____ Date processed: ____/____/___

Paying your plan premium

You can pay your monthly plan premium, if there is one, (including any late enrollment penalty that you may have) by mail or electronic funds transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare or RRB. Do NOT pay Priority Health the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at *www.socialsecurity.gov/prescriptionhelp*. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month. **Please select a premium payment option:**

☐ Get a bill monthly and pay the plan directly by mail.
☐ Electronic funds transfer (EFT) from your bank account each month. On the first or tenth day of every month, the checking or savings account you designate will be debited for the total amount of your outstanding premium(s). If you have questions about the automatic bill payment plan or wish to request a monthly statement, please contact customer service at 888.389.6648. If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25. A second NSF return may result in termination of coverage or loss of EFT privileges.

Account holder's name (print)	Account type ☐ checking ☐ savings
	Transfer date ☐ 1st day of the month ☐ 10th day of the month
Name of financial institution	Bank account number
Bank routing number (9 digits on the bottom of the check for a checking account) or attach a copy of a voided check	
Account holder's signature	Date

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I receive monthly benefits from: ☐ Social Security ☐ RRB

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please read and answer these important questions:

1. Do you have end-stage renal disease (ESRD)? ☐ 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 doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional documentation.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Priority Health Medicare? ☐ 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. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes" please provide the following information:

   Name of institution: _____

   Address and phone number of institution (number and street): _____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

If you would prefer that we send you information in another format, contact us toll-free at 888.389.6648, from 8 a.m. – 8 p.m., seven days a week. TTY users should call 711.

STOP! Please read this important information

If you currently have health coverage from an employer or union, joining Priority Health Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Priority Health Medicare. 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 below

- **By completing this enrollment application, I agree to the following:** Priority Health Medicare plans are Medicare Advantage plans and have a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire calendar year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Oct. 15 - Dec. 7 of every year) or under certain special circumstances.
- Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Priority Health Medicare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that Priority Health Medicare provides coverage for me in the United States and around the world for emergency and urgent care.
- I understand that if Priority Health has not received my plan premium by the first of the month, they may send a notice letting me know that my membership in the plan may end if they do not receive my premium payment in full, within 90 calendar days.
- For **Priority**Medicare Key, **Priority**Medicare Value and **Priority**Medicare plan enrollees: I understand that beginning on the date Priority Health Medicare coverage begins, I must get all of my health care from Priority Health Medicare network providers, except for emergency or urgently needed services, out-of-area dialysis services and out-of-network services explicitly covered under my Priority Health Medicare Point of Service (POS) benefit plan. Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor Priority Health Medicare will pay for the services.**
- For **Priority**Medicare Ideal, **Priority**Medicare Merit and **Priority**Medicare Select plan enrollees: I understand that beginning on the date that Priority Health Medicare coverage begins using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Priority Health Medicare provides refunds for all covered benefits, even if I get services out-of-network.
- Services authorized by Priority Health Medicare and other services contained in my Priority Health Medicare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.
- **For Enhanced Vision, Dental and Hearing package enrollees,** I understand that the vision and dental services included in this package are offered through vendors contracted with Priority Health Medicare. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found in each individual (vision, dental or hearing) Certificate of Coverage document. The vision benefit is offered through EyeMed. In-network benefits apply to services provided by an EyeMed participating provider. Out-of-network benefits apply to services provided by a non-participating EyeMed provider. The dental benefit is offered through Delta Dental. In-network benefits apply to services provided by a Delta Dental Medicare Advantage PPO or Medicare Advantage Premier participating dentist, in Michigan, Ohio or Indiana. Out-of-network benefits apply to services provided by a non-participating Delta Dental provider. The hearing benefit is provided by Priority Health Medicare. In-network benefits apply to services provided by Priority Health Medicare participating providers. Out-of-network benefits apply to services provided by a non-participating Priority Health Medicare provider. Enrollment in this plan is generally for the entire calendar year. Although, I may leave this plan at any time. Please contact us or refer to your EOC (Chapter 4, Section 2.2) for instructions on how to disenroll. This form cannot be used to disenroll from the enhanced vision, dental and hearing package.
- I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Priority Health Medicare, he/she may be paid based on my enrollment in Priority Health Medicare.
- **Release of Information:** By joining this Medicare health plan, I acknowledge that Priority Health Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Priority Health Medicare 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. 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 under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: _____ Today's date: ___/___/_____

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

Name: _____ Address: _____

Phone number: ( ) _____ Relationship to enrollee: _____

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