Presbyterian MediCare PPO
2024 Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call us at **(505) 923-8458** or **1-800-347-4766**. TTY users can call 711.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC), provides a complete list of coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **www.phs.org/medicare** or call **(505) 923-8458** or **1-800-347-4766**, TTY users can call 711, to view a copy of the EOC.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.

- ☐ This plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information.

Presbyterian MediCare PPO
2024 Individual Enrollment Request Form

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 United States
- 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 to December 7 each year (for coverage starting January 1)
- Within three 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.
- If your plan has a premium, 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:
Presbyterian Insurance Co., Inc.
P.O. Box 26267
Albuquerque, NM 87125-6267
Fax: (505) 923-5385

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

How do I get help with this form?

Call Presbyterian MediCare PPO at 505) 923-8458 or 1-800-347-4766. 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 Presbyterian MediCare PPO al (505) 923-8458 o 1-800-347-4766/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.

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Section 1 – All fields on this page are required (unless marked optional)			
Select the plan you want to join:			
Part D Drugs are included: _____ **Presbyterian MediCare PPO Plan 2 With Rx** - $164 per month			
Part D Drugs are not included: _____ **Presbyterian MediCare PPO Plan 1** - $43 per month			
Optional Supplemental Benefit: _____ **Comprehensive Dental** - $24.10 per month			
FIRST Name: LAST Name: Middle Initial: (Optional)			
Birth Date: (M M / D D / Y Y Y Y) (__ __ /__ __ /__ __ __ __)	Sex: ☐ M ☐ F	Phone Number: (Cell Preferred) ( )	Email:
Permanent Residence Street Address (Don't enter a P.O. Box):			
City:	County:	State:	ZIP Code:
Mailing Address, if different from your permanent address (P.O. Box allowed):			
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 Presbyterian MediCare PPO? ☐ Yes ☐ No If yes, name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____			

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IMPORTANT – Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Presbyterian MediCare PPO.
- By joining this Medicare Advantage (MA) Plan, I acknowledge that Presbyterian MediCare PPO 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).
- 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).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- 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 Presbyterian MediCare PPO has worldwide emergency/urgent care services.
- I understand that when my Presbyterian MediCare PPO coverage begins, I must get all of my medical and prescription drug benefits from Presbyterian MediCare PPO. Benefits and services provided by Presbyterian MediCare PPO and contained in my Presbyterian MediCare PPO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Presbyterian MediCare PPO will pay for benefits or services that are not covered.
- 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:

Office Use Only:

Name of staff member, agent or broker (if assisted in enrollment):

_____

Broker NPN# _____ Date Received: _____

How was enrollment received: ☐ Walk-in with presentation ☐ In Home with presentation
☐ Seminar/Meeting ☐ Telephonic ☐ Walk-in without presentation
☐ In Home without presentation ☐ Mail in ☐ Email ☐ Faxed

Plan ID#_____Effective date of coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

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Section 2 – All fields on this page are optional Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

I may need help accessing care or benefits and would like to be contacted (check all that apply):
☐ Find a new primary care provider (PCP)
☐ Transfer prescription/medication (e.g., coverage, cost, mail order)
☐ Care coordination (for example, if you have complex healthcare needs)

As part of your enrollment, do you want to receive any of the following materials via email?
☐ Plan Formulary ☐ Summary of Benefits ☐ Evidence of Coverage

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a or Spanish origin
☐ Yes, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ I choose not to answer

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ I choose not to answer

All materials are available in Spanish and a machine-readable format through our website or by request. Other options, such as other languages, large print or Braille are available by request. Please contact Presbyterian MediCare PPO at **(505) 923-6060** or **1-800-797-5343**. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31, and Monday to Friday (except holidays) from April 1 through September 30. TTY users can call 711.
Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other _____

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

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Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", credit card each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a payment option:

☐ Get a bill.

☐ Electronic Funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:
Account holder name: _____
Bank routing number: _____ Bank account number:_____
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:
Type of Card: ☐ Visa ☐ MasterCard ☐ Discover
Name of Account holder as it appears on card: _____
Account number: _____ Expiration Date: _ _ / _ _ _ _ (MM/YYYY)

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

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). **DON'T** pay Presbyterian the Part D-IRMAA.