

Presbyterian Dual Plus (HMO D-SNP) 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 provider directory (or ask your doctor) to make sure the providers you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- 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

- If your plan has a premium, 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.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- 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 Dual Plus (HMO D-SNP)
2024 Individual Enrollment Request Form**

<p>Who can use this form?</p> <p>People with Medicare who want to join a Medicare Advantage Plan</p> <p>To join a plan, you must:</p> <ul style="list-style-type: none"> • Be a United States citizen or be lawfully present in the United States • Live in the plan’s service area <p>Important: To join a Medicare Advantage Plan, you must also have both:</p> <ul style="list-style-type: none"> • Medicare Part A (Hospital Insurance) • Medicare Part B (Medical Insurance) 	<p>Reminders:</p> <ul style="list-style-type: none"> • 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.
<p>When do I use this form?</p> <p>You can join a plan:</p> <ul style="list-style-type: none"> • 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 <p>Visit Medicare.gov to learn more about when you can sign up for a plan.</p>	<p>What happens next?</p> <p>Send your completed and signed form to: Presbyterian Health Plan, Inc. P.O. Box 27489 Albuquerque, NM 87125-7489 Fax: (505) 923-5385</p> <p>Once we process your request to join, we’ll contact you.</p>
<p>What do I need to complete this form?</p> <ul style="list-style-type: none"> • Your Medicare Number (the number on your red, white and blue Medicare card) • Your permanent address and phone number <p>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.</p>	<p>How do I get help with this form?</p> <p>Call Presbyterian Dual Plus (HMO D-SNP) 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.</p> <p>En español: Llame a Presbyterian Dual Plus (HMO D-SNP) 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.</p>
	<p>Individuals experiencing homelessness</p> <p>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.</p>

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Section 1 – All fields on pages 1 and 2 are required (unless marked optional)

Select the plan you want to join:

This plan is for individuals with both Medicare and Medicaid. Premium is based on your Low Income Subsidy (LIS) level. Your Plan premium could be paid for by Medicare.

Presbyterian Dual Plus (DSNP)

H3204-013-004 Available in these counties: Bernalillo, Catron, Cibola, Colfax, De Baca, Doña Ana, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Rio Arriba, Sandoval, San Miguel, Santa Fe, Sierra, Socorro, Taos, Torrance, Union, or Valencia

H3204-013-005 Available in these counties: Chavez, Curry, Quay, Roosevelt or San Juan

FIRST Name: _____ LAST Name: _____ Middle Initial: (Optional) _____

Birth Date: (M M / D D / Y Y Y Y) (___ / ___ / _____)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number: (Cell Preferred) ()	Email:
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Permanent Residence Street Address (Don't enter a P.O. Box): _____

City:	County:	State:	ZIP Code:
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Mailing Address, if different from your permanent address (P.O. Box allowed): _____

City:	State:	ZIP Code:
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Your Medicare information:

Medicare Number: _____ - _____ - _____

Answer these important questions:

1. Are you enrolled in your state Medicaid Program? Yes No
If yes, Medicaid number: _____

2. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Presbyterian Dual Plus (HMO D-SNP)? Yes No
If yes, name of other coverage: _____
Member number for this coverage: _____
Group number for this coverage: _____

**Presbyterian Dual Plus (HMO D-SNP)
2024 Individual Enrollment Request Form**

IMPORTANT – Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Presbyterian Dual Plus (HMO D-SNP).
- By joining this Medicare Advantage (MA) Plan, I acknowledge that Presbyterian Dual Plus (HMO 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 Presbyterian Dual Plus (HMO D-SNP) coverage begins, I must get all of my medical and prescription drug benefits from Presbyterian Dual Plus (HMO D-SNP). Benefits and services provided by Presbyterian Dual Plus (HMO D-SNP) and contained in my Presbyterian Dual Plus (HMO D-SNP) “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Presbyterian Dual Plus (HMO 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:
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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 No broker

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, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican Yes, Cuban
- Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer

What's your race? Select all that apply.

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

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 Dual Plus (HMO D-SNP) **(505) 923-7675** or **1-855-465-7737**. 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 Senior Care (HMO) the Part D-IRMAA.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2025.