2022 Presbyterian MediCare PPO 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

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a provider. Visit **www.phs.org/medicare** or call **(505) 923-8458** or **1-800-347-4766**, TTY users can call 711, for a copy of the EOC.

- ☐ Review the provider directory (or ask your provider) 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 provider.

- ☐ 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.

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, 2023.

- ☐ 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 co-pay for services received by non-contracted providers.

2022 Presbyterian MediCare PPO 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 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:

Presbyterian Insurance Co., Inc.
P.O. Box 26267
Albuquerque, NM 87125-6267
Fax: (505) 923-5385

Once we process your request to join, we 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) 923-5458 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.

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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:			
Part D Drugs are included: _____ Presbyterian MediCare PPO Plan 2 with Rx - $188 per month			
Part D Drugs are not included: _____ Presbyterian MediCare PPO Plan 1- $43 per month			
Optional Supplemental Benefit: _____ Comprehensive Dental - $19 per month			
FIRST Name:	LAST Name:		Middle Initial:
Birth Date: (__ __ /__ __ /__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Phone Number: ( )	Email (optional):
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:	County:	State:	ZIP Code:
Your Medicare information:			
Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __			
Answer this important question:			
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 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).
- 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 # _____

How was enrollment received: _____ Date Received: _____

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.

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

Would like to go paperless for your Explanation of Benefits and Annual Notice of Change documents? ☐ Yes, I want to go paperless. ☐ No, continue to send by mail.

Email address: _____

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:

Paying your plan premiums

You can pay your plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or 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: _____

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 MediCare PPO the Part D-IRMAA.