CareFirst Medicare Advantage

Enrollment Instructions

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
- Have a Medicaid level of Full Benefit Dual Eligible (FBDE) or Qualified Medicare Beneficiary (QMB).

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:

CareFirst BlueCross BlueShield Medicare Advantage
Attn: Sales Department
PO Box 915
Owings Mills, MD 21117

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

How do I get help with this form?

Call CareFirst BlueCross BlueShield Medicare Advantage at 1-844-331-6334. 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 CareFirst BlueCross BlueShield Medicare Advantage al 1-844-331-6334 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible paraasistirle.

CareFirst

Medicare Advantage

OMB No. 0938-1378
Expires: 7/31/2023

Section 1 - All Fields on this Page are Required (unless marked optional):

Select the plan you want to join:

☑ **DUAL PRIME:** $0 - $32.30 per month (Based on your level of "Extra Help")

FIRST Name:	LAST Name:	Middle Initial:

Birth Date: (MM/DD/YYYY) _____/_____/_____	Sex: ☐ Male ☐ Female	Home Phone Number: (_____)_____-_____	Cell Phone Number: (_____)_____-_____

Email Address (optional)**:**

I authorize the health plan to text and email me helpful reminders, articles and tips on healthy living, surveys, and general information about the plan. I understand that I may opt-out of receiving these messages by contacting Member Services at 1-844-386-6762 (TTY: 711), 8 am - 8 pm, ET, 7 days a week from Oct. 1 - Mar. 31 and 8 am - 8 pm, ET, Monday - Friday from Apr. 1 - Sept. 30.

☐ **Yes, I would like to receive messages** ☐ **No, I do not want to receive messages**

Permanent Residence Street Address **(Don't enter a PO Box)**:			Apt. Number:
City:	County:	State:	ZIP code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address:_____Apt. Number:_____

City: _____State:_____ ZIP code:_____

Your Medicare Information:

Medicare Number: ____ ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

Answer these Important Questions:

1. Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage?

☐ Yes ☐ No Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your 11-digit Medicaid number: _____

To be eligible for Dual Prime, you must have a Medicaid level of Qualified Medicare Beneficiary (QMB) or Full Benefit Dual Eligible (FBDE).

3. Are you a resident of a long-term facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Facility: _____ Phone Number of Facility: _____

Address of Facility: _____

✔	Information to Determine Your 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 if the statement 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 this information is incorrect, you may be disenrolled.	
	I am new to Medicare.
	I am making a change during the Annual Enrollment Period (AEP) from October 15 to December 7.
	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) from January 1 to March 31.
	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 recently was released from incarceration. I was released 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) _____.
	I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
	I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
	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 am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
	I recently left a PACE program on (insert date) _____.
	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
	I am leaving employer or union coverage on (insert date) _____.
	I belong to a pharmacy assistance program provided by my state.
	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
	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 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 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.
	I am enrolled in a plan that is experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership.
	I am enrolled in a plan that has been identified with the low performing icon (LPI).
If none of these statements applies to you or you're not sure, please contact CareFirst BlueCross BlueShield Medicare Advantage at **1-844-331-6334 (TTY: 711)** to see if you are eligible to enroll. We are open October 1 through March 31, seven days a week from 8 am - 8 pm, and April 1 through September 30, Monday through Friday from 8 am - 8 pm.	
Section 2 - All Fields in this Section are Optional Answering these questions are your choice. You can't be denied coverage because you don't fill them out.	
1. Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ Spanish ☐ Braille ☐ Large print Please contact CareFirst BlueCross BlueShield Medicare Advantage at 1-844-386-6762 if you need information in an accessible format or language other than what is listed above. Our office hours are 8 am - 8 pm ET, 7 days a week, October 1 - March 31; 8 am - 8 pm ET, Monday - Friday, April 1 - September 30. TTY users should call 711.	
2. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No	

3. Please choose the name of a Primary Care Physician (PCP). Refer to the plan website or Provider & Pharmacy Directory to choose.

PCP Name _____

PCP Address _____

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

Paying Your Plan Premium:

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) 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. 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 monthly 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 CareFirst BlueCross BlueShield Medicare Advantage the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank checking account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

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

I get monthly benefits from: ☐ Social Security ☐ RRB

IMPORTANT - Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Medicare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Medicare Advantage 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my CareFirst BlueCross BlueShield Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Medicare Advantage and contained in my CareFirst BlueCross BlueShield Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Medicare Advantage 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.

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)," System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Signature:
Today's Date:
If you're the authorized representative, sign above and fill out these fields:
Name:
Address:
Phone Number:
Relationship to Enrollee:

Agent Use Only:
Agent Name:
Agent ID:
Initial Receipt Date:
Proposed Effective Date of Coverage:
LIS Level: