New York

bright HEALTH

Bright Health Medicare Advantage Enrollment Form

Individual enrollment request form to enroll in a Medicare Advantage Plan (Part C) or Medicare Prescription Drug Plan (Part D)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug 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 Oct. 15 - Dec. 7 each year (for coverage starting Jan. 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 (Oct. 15 - Dec. 7)., the plan must get your completed form by Dec. 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:

Bright Health Medicare Advantage - Enrollment
P.O. Box 853958
Richardson, TX 75085-3958

FAX: **1-800-208-7647**

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

How do I get help with this form?

Call Bright Health Advantage Health Plan at **1-844-679-2030 (TTY: 711)**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a Bright Health Advantage Health Plan al **1-844-679-2030 (TTY: 711)** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

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

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

Contract	Plan Name	Plan Type	Premium
☐ H2288-010	Bright Advantage Senior Savings Assist	HMO C-SNP	$33.90*
☐ H2288-009	Bright Advantage Senior Savings	HMO C-SNP	$0

*Premium may vary depending on Medicaid level. For those with 100% subsidy, Medical Premium will be $0.
If you receive "Extra Help" also known as LIS (Low Income Subsidy), you may qualify for assistance with your monthly plan premium.

Section 1 – All fields on this page are required (unless marked optional)		
FIRST Name:	LAST Name:	Middle Initial (Optional):
Birthdate (MM/DD/YYYY): __ / __ / ____	Sex: ☐ M ☐ F	Phone Number: ___ - ___ - ____
Permanent Residence Street Address (Don't enter a P.O. Box):		

City:	County (Optional):	State:	ZIP Code:

Mailing Address, if different form 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 Bright Health Medicare Advantage plan? ☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

In order to qualify for a Chronic Condition Special Needs Plan, you must have one or more of the below chronic conditions:

Have you been diagnosed with one of the following? Please check all that apply.

☐ Congestive heart failure (CHF)

☐ Cardiovascular disease (CVD) (must be cardiac arrhythmia, coronary artery disease, peripheral vascular disease or chronic venous thromboembolic disorder)

☐ Diabetes mellitus (DM)

Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with the enrollment form.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Bright Health Medicare Advantage plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Bright Health Medicare Advantage plan 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 Bright Health Medicare Advantage plan coverage begins, I must get all of my medical and prescription drug benefits from Bright Health Medicare Advantage plan. Benefits and services provided by Bright Health Medicare Advantage plan and contained in my Bright Health Medicare Advantage plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Bright Health Medicare Advantage plan 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/broker (if assisted in enrollment): ______________________

Agent NPN: ______________________

Plan ID#: ______________________ Effective Date of Coverage: __________

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

Broker Received date: ______________________

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.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Other

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Bright Health Medicare Advantage plan at **1-844-679-2030** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays. TTY users can call **711**.

Do you work? ☐ Yes ☐ No Does your Spouse work? ☐ Yes ☐ No

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

I want to get the following materials via email. Select one or more.

☐ I want to get plan materials electronically when available. I understand that I can request a paper copy at any time.

Email address: ______________________

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.

Section 2 (Continued) – All fields on this page are optional

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 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 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 Bright Health the Part D-IRMAA.

Please select a premium payment option

☐ **Monthly Invoice**

☐ **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

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

I get 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 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" section to send your completed form to the plan.

Bright Health Pre-Enrollment Qualification Assessment Tool

IMPORTANT: Complete if Enrolling in a Chronic Condition Special Needs Plan

Bright Advantage Senior Savings (HMO C-SNP) and Bright Advantage Senior Savings Assist (HMO C-SNP) are Special Needs Plans (SNPs) for individuals with diabetes, congestive heart failure and certain cardiovascular disorders. To enroll in these plans, Medicare requires that Bright Health verify your chronic condition. This is a two-step process:

Step One

Please complete this form and return it to us with your completed enrollment application. If you can answer “yes” to at least one of the chronic condition questions, you may pre-qualify for enrollment in a Bright Health Chronic Condition SNP (C-SNP).

Step Two

Bright Health must verify your chronic condition within 30 days of your enrollment.
Note: If we are unable to verify your chronic condition, we must disenroll you from the C-SNP. That is why it is important to give us contact information for a doctor or clinic that can verify your condition (see page 3 of this form).

<table>
<tr><th colspan="4">Applicant information</th></tr>
<tr><td>LAST Name:</td><td colspan="2">FIRST Name:</td><td>Middle Initial (Optional):</td></tr>
<tr><td>Birthdate (MM/DD/YYYY):
___ / ___ / _____</td><td colspan="3">Medicare Number:
_____ - ____ - _____</td></tr>
<tr><td colspan="2">Phone Number:
____ - ____ - _____</td><td colspan="2">Alternate Phone Number (cell):
____ - ____ - _____</td></tr>
<tr><td colspan="4">☐ By checking this box, you authorize Bright Health and its affiliates to send you text messages with information related to your health plan.</td></tr>
<tr><td colspan="4">Email address: ____
☐ By checking this box, you authorize Bright Health and its affiliates to send you information related to your health plan by email.</td></tr>
</table>

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Chronic Condition Questions		
Diabetes Mellitus (DM) (Note: a pre-diabetes diagnosis does not qualify for this plan)		
1. Have you ever been told by a doctor that you have diabetes?	☐ Yes	☐ No
2. Do you take or has your doctor prescribed insulin or another medication for diabetes treatment?	☐ Yes	☐ No
3. Have you been put on a special diet by your doctor or a registered dietician to treat your diabetes?	☐ Yes	☐ No
Congestive Heart Failure (CHF)		
1. Have you ever been told by a doctor that you have congestive heart failure (CHF)?	☐ Yes	☐ No
2. Do you take medication to prevent fluid build-up in your lungs or have you had problems with fluid in your lungs or swelling in your legs, accompanied by shortness of breath, due to a heart problem?	☐ Yes	☐ No
3. During the past 12 months, have you been counseled or educated by a health care professional about weighing yourself daily to monitor a heart problem?	☐ Yes	☐ No
Cardiovascular Disorder (CVD)		
1. Have you ever been told by a doctor that you have any of the following?		
a. Cardiac arrhythmia (heart rhythm problems like atrial fibrillation (“AFib”) or rapid or irregular heartbeats)	☐ Yes	☐ No
b. Coronary artery disease (heart disease)	☐ Yes	☐ No
c. Blood clots or blood circulation problems in your legs (peripheral vascular disease)	☐ Yes	☐ No
d. Chronic venous thromboembolic disorder (blood clots in your veins)	☐ Yes	☐ No
2. Have you ever had a stroke?	☐ Yes	☐ No
3. Have you ever had a heart attack or a stent placement?	☐ Yes	☐ No

Health care provider(s) who can verify your chronic condition(s)	
Provider #1	**Provider #2**
Provider Name:	Provider Name:
Provider Phone Number: ____ - ____ - _____	Provider Phone Number: ____ - ____ - _____
Provider Fax Number: ____ - ____ - _____	Provider Fax Number: ____ - ____ - _____
Clinic Location:	Clinic Location:

Authorization for use and disclosure of health information to verify chronic condition(s) for purpose of health plan eligibility

I authorize the providers listed above to disclose my health information to Bright Health to verify that I have been diagnosed with a chronic condition that qualifies me for enrollment in a Bright Health Chronic Condition Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth above, consistent with state and federal law concerning the privacy of such information.

Applicant Name (printed): ______________________________

Applicant/Authorized Representative Signature: ______________________________

Date: ____________________

To be completed by provider or provider representative

Provider Attestation
For the purpose of confirming eligibility to enroll in a Chronic Condition Special Needs Plan, I hereby attest that the Applicant identified above has the following health condition(s):

- Diabetes Mellitus (DM) (pre-diabetes excluded) ☐ Yes ☐ No
- Congestive Heart Failure (CHF) ☐ Yes ☐ No
- Cardiovascular Disorder (please specify the CVD):
  - Cardiac arrhythmia ☐ Yes ☐ No
  - Coronary artery disease ☐ Yes ☐ No
  - Peripheral vascular disease ☐ Yes ☐ No
  - Chronic venous thromboembolic disorder ☐ Yes ☐ No

Provider Name (printed): ______________________________

Provider or Provider Representative Signature: ______________________________

Today's Date: ____________

Please return this form to Bright Health within three (3) business days of receipt

By Fax:
1-800-208-7647
ATTN: Bright Health Medicare Advantage – Enrollment

By Mail:
Bright Health Medicare Advantage – Enrollment
P.O. Box 853958
Richardson, TX 75085 - 3958

If you have any questions about this form, please call: **1-844-223-8380**, 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays.