2023 Providence Medicare Advantage Enrollment Packet

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

Enrollment Packet – click links below to view the information
Star Rating Download Application: Clark County / Focus & Reverence CC / Reverence (other) / Cottonwood & Pine Summary of Benefits: Bridge 2 / Choice 2 / Extra 2 / Timber / Cottonwood / Pine / Focus / Reverence Pharmacy & Provider Search Formulary: Extra Rx 001 & 002 / All others

Initial Enrollment Period (IEP)
If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.
Annual Enrollment Period (AEP)
Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.
Special Enrollment Period (SEP)
There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2023 Pending

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2023 MEDICARE ADVANTAGE 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?

Submit your completed and signed form using one of the three options below:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

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

How do I get help with this form?

Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495**. 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 Providence Medicare Advantage Plans al **503-574-6508** or **1-855-234-2495/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.

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?" on this page to send your completed form to the plan.

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

Select the plan you want to join:

☐ Providence Medicare Reverence (HMO-POS) - $51 per month

To enroll in an Optional Supplemental Dental Plan*, please select the plan you want to join:

☐ **OR Basic:** $32.50 per month.

☐ **OR Enhanced:** $45.10 per month.

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional supplemental dental plan selected. Additionally, I understand that I must pay the optional supplemental dental plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

FIRST name ______________ LAST name ______________ Middle Initial (Optional) ______

__ __/__ __/__ __ __ __ Birth date (MM/DD/YYYY)

SEX: ☐ Male ☐ Female

(   )   - Phone number

Permanent Residence street address (Don't enter a PO Box) ______________

City ______ County (Optional) ______ State ______ ZIP code ______

Mailing address, if different from your permanent address (PO Box allowed):

Street Address ______________

City ______ State ______ ZIP code ______

Your Medicare information:

__ __ __ __-__ __ __-__ __ __ __ Medicare Number

__ __/__ __/__ __ __ __ Hospital (Part A) Effective Date (Optional)

__ __/__ __/__ __ __ __ Medical (Part B) Effective Date (Optional)

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Answer these important questions:

Will you have other coverage in addition to Providence Medicare Advantage Plans? ☐ Yes ☐ No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If "yes," please list your other coverage and your identification (ID) number for this coverage.

____
Name of other coverage

____________________ ______________________
ID number for this coverage Group number for this coverage

Check all that apply: ☐ Medical ☐ Vision ☐ Dental ☐ Prescription

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IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Providence Medicare Advantage Plans.
- By joining this Medicare Advantage Plan I acknowledge that Providence Medicare Advantage Plans 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).
- 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 when my Providence Medicare Advantage Plans coverage begins, I must get all of my medical and prescription drug benefits from Providence Medicare Advantage Plans. Benefits and services provided by Providence Medicare Advantage Plans and contained in my Providence Medicare Advantage Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Providence Medicare Advantage Plans 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 are the authorized representative, sign above and fill out these fields:

______________________ Name

______________________ Address

(   )   – ______________ Phone number

______________________ Relationship to enrollee

______________________ AGENT NAME

___ ___/___ ___/___ ___ DATE

______________________ NPN #

___ ___/___ ___/___ ___ REQUESTED DATE OF COVERAGE

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.

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
- ☐ 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.**

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

____

If you do not provide a PCP, one will be assigned.

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time). TTY users can call 711.

Do you work?

☐ Yes ☐ No

Does your spouse work?

☐ Yes ☐ No

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 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 premium payment option:

☐ Get a monthly bill – Once you receive your first bill, you can choose a different payment option:

+ You can pay by credit/debit card or checking/savings account: One-time or recurring payments can be made via your myProvidence account at myProvidence.com or through the Providence website at providence.org/premiumpay.
+ You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 1-844-791-1468, TTY: 711.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit 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. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

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Attestation of Eligibility for an 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 that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage 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 am enrolling during the Annual Enrollment Period (October 15-December 7)
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used) ______________________________
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-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 belong to a pharmacy assistance program provided by my state.
- ☐ I recently left a PACE program 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 the facility on (insert date):____ ____/____ ____/____ ____ I moved/will move out of the facility 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):____ ____/____ ____/____ ____
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (insert date):____ ____/____ ____/____ ____

- [ ] 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State or local government entity.)

  One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

  Name of disaster impacted by:

  ____

  Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

  ____

- [ ] I was impacted by a significant network change with my current plan and was notified on (insert date):____ ____ /____ ____/____ ____
- [ ] I recently received notice of a Medicare entitlement determination for a retroactive effective date. (Please attach a copy of your entitlement notice.) I was notified on (insert date):____ ____ /____ ____/____ ____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Race/Ethnicity Questionnaire

Providence
Medicare Advantage Plans

The following questions are optional. Your responses will help us to better serve all communities.

If you did not find a selection that best describes your racial or ethnic identity in Section 2, please make a selection from the following list. Which of the following describes your racial or ethnic identity? Please check all that apply.

Native Hawaiian or Pacific Islander

- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Tongan

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Other

- ☐ Other
- ☐ I don’t know.
- ☐ I don’t want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Asian

- ☐ Cambodian
- ☐ Communities of Myanmar
- ☐ Hmong
- ☐ Laotian
- ☐ South Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): ____________________
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don’t know.
- ☐ **N/A:** I don’t want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ Decline/Unknown

If you did not find a selection that best describes your gender identity in Section 1, please make a selection from the following list. How do you identify?

- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Non-binary
- ☐ Other
- ☐ Don’t know
- ☐ Decline to Answer