Medica

PO Box 9310, Minneapolis, MN 55440-9310

Medica DUAL Solution® (HMO D-SNP) Enrollment Form

Medical DUAL Solution Enrollment Telephone Numbers:
1 (800) 266-2157 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, seven days a week. The call is free.
Please note: Access to a representative is limited on the weekends/holidays during certain times of the year.

Medica DUAL Solution Member Services Telephone Numbers:
1 (888) 347-3630 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, seven days a week. The call is free.
Please note: Access to a representative is limited on the weekends/holidays during certain times of the year.

Medical and Prescription Drug questions:
1 (888) 347-3630 (TTY for the hearing impaired at 711) 8 a.m.-8 p.m. CT, seven days a week. The call is free.
Please note: Access to a representative is limited on the weekends/holidays during certain times of the year.

Return the completed form, pages 2-7 to Medica DUAL Solution:
Mail Route CW140
PO Box 9310
Minneapolis, MN 55440-9310

Fax Number: (952) 992-2682

Medica DUAL Solution is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) Program to provide benefits of both programs to enrollees. Enrollment in Medica DUAL Solution depends on contract renewal.

For accessible formats of this publication or assistance with additional equal access to our services, write to Medica.com/ContactMedicaid, call 1 (888) 347-3630 (toll free) or use your preferred relay service.

Copies: white/top copy Medica DUAL Solution yellow/bottom copy - Member
(PLEASE KEEP YELLOW COPY FOR YOUR RECORDS)

Member Name: _____ MHCP Member Number: _____

Medica DUAL Solution® (HMO D-SNP) Enrollment Request Form

To join Medica DUAL Solution, you must have **Medicare Part A, Medicare Part B** and **Medical Assistance (Medicaid), and** be age 65 or over **and** live in Medica DUAL Solution's service area.

Section 1. Tell us about yourself:

1	**Name: (first, middle, last)**			
2	**Date of birth: (_ _ / _ _ / _ _ _ _)** **MM / DD / YYYY**		**Sex: ❑ Female ❑ Male**	
3	**Phone number:** **(____) ____ - _____**		**Another phone number (Optional):** **(____) ____ - _____**	
4	**Address where you live (PO Box is not allowed):**			
	City:	**State:**	**ZIP code:**	**County:**
5	**Address where you get mail (if different from where you live):**			
	City:	**State:**	**ZIP code:**	**County:**
6	**Do you live in a long-term care facility? ❑ Yes ❑ No** If yes, fill in the information below:			
	Name of the facility:		**Phone number:** **(____) ____ - _____**	
7	**Do you need an interpreter? ❑ Yes ❑ No** If yes, check the language below: ❑ 01 Spanish ❑ 02 Hmong ❑ 03 Vietnamese ❑ 04 Khmer (Cambodian) ❑ 05 Lao ❑ 06 Russian ❑ 07 Somali ❑ 08 ASL (American Sign Language) ❑ 09 Amharic ❑ 10 Arabic ❑ 12 Oromo ❑ 14 Burmese ❑ 15 Cantonese ❑ 16 French ❑ 20 Korean ❑ 21 Karen ❑ 98 Other _____			
8	**Authorized Representative:**		**Authorized Representative phone number:** **(____) ____ - _____**	

Member Name: _____ MHCP Member Number: _____

Section 2. Tell us more about yourself:

You are not required to answer questions or give any information in this section. It's your choice to share this information with us. We can't deny you coverage if you don't answer them.

<table>
<tr><td>9</td><td colspan="2">Do you want us to send you information in a language other than English?

❑ Yes ❑ No If yes, write language: _____.</td></tr>
<tr><td>10</td><td colspan="2">Do you want us to send you information in an accessible format?

❑ Yes ❑ No If yes, check correct format below:

❑ Braille ❑ Large print ❑ Audio

Please contact Medica DUAL Solution at 1 (888) 347-3630 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m.-8 p.m. CT, seven days a week. TTY users can call 711.</td></tr>
<tr><td>11</td><td colspan="2">Do you want to get information by email?

❑ Yes ❑ No If yes, provide your email address below:

Email: _____</td></tr>
<tr><td>12</td><td>Do you work?

❑ Yes ❑ No</td><td>Does your spouse or domestic partner work?

❑ Yes ❑ No ❑ Does not apply</td></tr>
<tr><td>13</td><td>Name of the primary care clinic/care system you are choosing:</td><td>Primary care clinic/care system provider ID number found in the Provider and Pharmacy Directory:</td></tr>
</table>

Member Name: _____ MHCP Member Number: _____

Section 3. Tell us about your Medicare and Medical Assistance (Medicaid) coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

14	**Medicare Number:** _____	**MHCP Member Number:** _____

Section 4. Tell us about your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

15	**Do you have other health coverage?** ❑ **Yes** ❑ **No** If yes, fill in the information below:	
16	**Name of your plan (and employer, if applicable):**	**Group Number:** **ID Number:**

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join Medica DUAL Solution. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Member Name: _____ MHCP Member Number: _____

Section 5. Tell us about your enrollment eligibility.

Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply.** 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 applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.
- ❑ I am new to Medicare.
- ❑ I have both Medicare and Medical Assistance (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 recently had a change in my Medical Assistance (Medicaid) (newly got Medicaid or had a change in level of Medicaid assistance) on __ /__ /__ (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__ /__ /__ (date).
- ❑ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on__ /__ /__ (date).
- ❑ 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__ /__ /__ (date).
- ❑ I am leaving employer or union coverage on__ /__ /__ (date).
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on__ /__ /__ (date).
- ❑ 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__ /__ /__ (date).
- ❑ I recently was released from incarceration. I was released on__ /__ /__ (date).
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on__ /__ /__ (date).
- ❑ I recently obtained lawful presence status in the United States. I got this status on__ /__ /__ (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.

If none of these statements apply to you or you're not sure, please contact Medica DUAL Solution at **1 (888) 347-3630** (TTY users should call 711) to find out if you're eligible to enroll. We are open 8 a.m.-8 p.m. CT, seven days a week. Please note: Access to a representative is limited on the weekends/holidays during certain time of the year.

Member Name: _____ MHCP Member Number: _____

Please read the information on page and sign below.

When you sign this form, it means that you understand the information you read.

_____

Name of Applicant (Please print)

_____ _____

Signature Today's Date

If you are the authorized representative, **you must sign above** and provide the following information.

_____ _____

Name (Print) Relationship to Enrollee

_____ _____

Address (Print) Telephone Number

When the form is completed, mail or fax pages 2-7 to Medica DUAL Solution.
Our address and fax number are on page 1.

Office Use Only: Date: _____

Name of Authorized Sales Rep: _____

LIS Copay Level: _____

Effective Date of Enrollment: _____

LIS Copay Effective Date: _____

Election Code: _____

Approved By: _____

Member Name: _____ MHCP Member Number: _____

Information and Acknowledgement Statements

- My response to this form is voluntary. I understand that my enrollment in Medica DUAL Solution may be affected if I don't respond.
- I must keep Medicare Part A and Part B and Medical Assistance (Medicaid) to stay in Medica DUAL Solution.
- By joining Medica DUAL Solution, I acknowledge that the 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 collection of this information (see Privacy Act Statement below).
- On the date Medica DUAL Solution coverage begins, I must get my Medical and prescription drug benefits from Medica DUAL Solution.
- Benefits and services Medica DUAL Solution provides and contained in my *Member Handbook* are covered. Neither Medicare nor Medica DUAL Solution will pay for benefits or services that are not covered.
- I understand that Medica DUAL Solution doesn't usually cover people while they're out of the country except under limited circumstances.
- If I am now getting Elderly Waiver services through the county, I am aware that my case manager may be replaced by a different county case manager or a health plan care coordinator.
- If I move, I need to tell my County Worker.
- I can choose to leave Medica DUAL Solution at certain times of the year. I understand that I will be enrolled in Medica DUAL Solution through the last day of the month. I understand that I will be automatically enrolled in the Minnesota Senior Care Plus (MSC+) plan, which will cover my Medical Assistance (Medicaid) benefits. If I ask in writing, I will be enrolled in my previous MSC+ plan.
- If I get a medical spenddown while enrolled in Medica DUAL Solution and do not pay it to the State, I will be disenrolled from Medica DUAL Solution.
- The information on this enrollment form is correct to the best of my knowledge. I understand that I will be disenrolled from Medica DUAL Solution if I intentionally give false information on this form.
- My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid).

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 and 1860D-1 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.

Medica Member Services
1 (888) 347-3630 (toll free) TTY: 711

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ: ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ် ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillex appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တိလ်ာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လိတဲစီနိုဂ််လၢထးအံၤနူဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị c`ần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

CB5 (MCOs) (5-2020)

Civil Rights Notice

Discrimination is against the law. Medica does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: Medica provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact Medica at 1-888-347-3630 (toll free); TTY: 711 or at medica.com/contactmedicaid.

Language Assistance Services: Medica provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact Medica at 1-888-347-3630 (toll free); TTY: 711 or at medica.com/contactmedicaid.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Medica. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Medica Complaint Notice

You have the right to file a complaint with Medica if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Medica Civil Rights Coordinator
Medica Health Plans
PO Box 9310, Mail Route CP250
Minneapolis, MN 55443-9310
952-992-3422 (voice and fax) TTY: 711
Email: civilrightscoordinator@medica.com

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.