MEDICA®

PO Box 9310, Minneapolis, MN 55440-9310

Medica AccessAbility Solution® Enrollment Form

Medica AccessAbility Solution® Enrollment Telephone Numbers:
1 (952) 992-2030 or toll-free 1 (800) 266-2157. TTY users, please call 711
Days and hours of operation: 8 a.m. to 5 p.m., Monday through Friday.
The call is free.

Medica AccessAbility Solution® Member Services Telephone Numbers:
1 (952) 992-2580 or toll-free 1 (888) 347-3630. TTY users, please call 711
Days and hours of operation: 8 a.m. to 5 p.m., Monday through Friday.
The call is free.

You can speak to someone about getting this information for free in other languages.
Call 1 (952) 992-2580 or toll-free 1 (888) 347-3630. TTY users should call 711, 8 a.m. to 5 p.m.
Monday through Friday. The call is free.

Return the completed form, pages 6 to 7, to:
Medica AccessAbility Solution
Mail Route CW140
PO Box 9310
Minneapolis, MN 55440-9310

Fax Number: 1 (952) 992-2682

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

White Copy - Medica

Yellow Copy - Enrollee

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

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

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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။ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစီနိၣ်ဂ်ၢ်လၢထးအံၤနူဉ်တက့်။

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.

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Office Use Only:	Date: _____
Name of Authorized Sales Person:	

Medica AccessAbility Solution® Enrollment Form

Last name	First name	MI	Birth Dates MM / DD / YEAR	Gender ❑ M ❑ F
County you live in	Social Security Number (optional)	Phone Number (_____) - _____ - _____		
[redacted]		Another Phone Number: (_____) - _____ - _____		
Street address (where you live)		City	State	Zip code
Mailing address (if different from where you live)		City	State	Zip code
Email address (optional)				
Medical Assistance ID number (PMI)	Case number	Are you pregnant? ❑ YES ❑ NO		

Do you need an interpreter? ❑NO ❑YES, if yes, check one of the boxes below

❑ Spanish (01) ❑ Hmong (02) ❑ Vietnamese (03) ❑ Khmer (Cambodian) (04) ❑ Lao (05)
❑ Russian (06) ❑ Somali (07) ❑ ASL (American Sign Language 08) ❑ Amharic (09) ❑ Arabic (10)
❑ Oromo (12) ❑ Burmese (14) ❑ Cantonese (15) ❑ French (16) ❑ Korean (20) ❑ Karen (21)
❑ Other (98), explain _____

Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver? ❑ YES ❑ NO

Do you have Medicare coverage? ❑ YES ❑ NO If Yes, fill in the information below:
Medicare (ID) number:
Hospital (Part A) Begin Date: Medical (Part B) Begin Date:

Do you live in a long-term facility? ❑ YES ❑ NO If yes, fill in the information below:
Name of the facility: Phone number: (____) ____- _____

Some individuals may have other medical coverage, including other private insurance.
Do you have other medical coverage? ❑ YES ❑ NO
If Yes, insurance company name: Policyholder's name:
Group number: Policy/ID number: Is this insurance through an employer? ❑ YES ❑ NO

CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to drop out and change back to Medical Assistance (Medicaid) fee-for-service effective the next available month.

Primary Care Clinic	Primary care clinic (PCC) number

Please read and sign this form

Under Medica AccessAbility Solution, I understand that:

Medica AccessAbility Solution will be providing my health care covered by Medical Assistance (Medicaid).
Once I am a member of Medica AccessAbility Solution, I have the right to appeal any services that are being denied, reduced, or stopped, or if Medica AccessAbility Solution is denying payment for services.
I will be notified of the date my coverage will start.
On the date Medica AccessAbility Solution coverage begins, I must get my health care from Medica AccessAbility Solution doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get Medica AccessAbility Solution approval to see other providers in some circumstances.
I will read the Member Handbook I get from Medica AccessAbility Solution. It will have the rules I must follow and more information about the services my plan covers. Services contained in Medica AccessAbility Solution's Evidence of Coverage will be covered.
Some services require authorization from Medica AccessAbility Solution. Without authorization, Medica AccessAbility Solution will not pay for these services.
My Medica AccessAbility Solution benefits cannot be canceled because I get sick or use health care services.
I can choose to leave Medica AccessAbility Solution and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month. I understand that I will be enrolled in Medica AccessAbility Solution through the last day of the month.
My health care services will be coordinated through Medica AccessAbility Solution.
To be enrolled and stay enrolled in Medica AccessAbility Solution, I must: ▪ Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) or be enrolled in the Developmental Disability waiver ▪ Be at least 18 years old and under 65 years old ▪ Be eligible for Medical Assistance (Medicaid) without a medical spenddown ▪ Either have no Medicare, OR have both Medicare Parts A and B ▪ Live in a county serviced by Medica AccessAbility Solution If this changes, I will notify my county worker and Medica AccessAbility Solution so I can disenroll.
If I get a medical spenddown while enrolled in SNBC and do not pay it to DHS, I will be disenrolled from Medica AccessAbility Solution.
If I am on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in Medica AccessAbility Solution, I authorize:

The sharing of information about my Medical Assistance (Medicaid) eligibility status and the information on this form among the state, its representatives, the county where I live and Medica AccessAbility Solution.
The information on this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of person authorized to act on my behalf under the laws of the state where I live) on this form means that I have read and understand the contents of the form. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized by state law to complete this enrollment form on my behalf, and 2) documentation of this authority is available upon request by the state or Medica AccessAbility Solution.

Signature of enrollee or authorized representative:	Date:

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

Name (print):	Relationship to enrollee:	Phone number:
Street address, City, State, Zip:		

Page 7 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax pages 6 to 7 to Medica AccessAbility Solution. Our address and fax number is on the cover.

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PO Box 9310, Minneapolis, MN 55440-9310

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