PO Box 9310, Minneapolis, MN 55440-9310

Medica DUAL Solution® (HMO SNP) Enrollment Form

Medical DUAL Solution Enrollment Telephone Numbers:
952-992-2030 or 1-800-266-2157, TTY Users: Call 711, 8 a.m. to 8 p.m., seven days a week.
The call is free.

Medica DUAL Solution Member Services Telephone Numbers:
952-992-2580 or 1-888-347-3630, TTY Users: Call 711, 8 a.m. to 8 p.m., seven days a week.
The call is free.

Medical and Prescription Drug questions:
952-992-2580 or 1-888-347-3630, TTY Users: Call 711, 8 a.m. to 8 p.m., seven days a week.
The call is free.

You can speak to someone about getting this information for free in other languages.
Call 952-992-2580 or 1-888-347-3630. TTY Users: Call 711.
The call is free.

If you would like to make a standing request to get materials in a language other than English or in alternate format, please call 952-992-2580 or 1-999-347-3630. TTY Users: Call 711.
The call is free.

Return the completed form, pages 5, 6, 7 and 9 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 Assistance Program (Medicaid) 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 Copy — Health Plan Yellow Copy — Enrollee
(PLEASE KEEP YELLOW COPY FOR YOUR RECORDS)

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Medica Customer Service

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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بسم تدرا ألاحظة: إمادعة جمانية لتجرمة هه الوثيذقصتة، ال علأعاله مقرى ال

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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, veuillez 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.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ၣ်, ကိးဘဉ်လီတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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 qoraalkan, lambarka kore wac.

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

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

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SPP-0718-C

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

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 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
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.

Member Name: ______________________________ Medical Assistance ID #: ______________________

- Medica DUAL Solution has a contract with the federal government and with the State of Minnesota.
- The health services I get with my new plan may be different than the services I had before.
- I must keep Medicare Part A and Part B and Medical Assistance (Medicaid).
- I can be in only one Medicare plan at a time.
- By joining Medica DUAL Solution, I will end my enrollment in another Medicare health or prescription drug plan.
- I must tell Medicare and Medical Assistance (Medicaid) about any prescription drug coverage that I have or may get in the future.
- If I move, I need to tell the County Worker.
- As a member of Medica DUAL Solution, I have the right to appeal if I don't agree with Medica DUAL Solution's decisions about payment or services.
- I understand that Medica DUAL Solution's Member Handbook includes the rules I must follow.
- Medica DUAL Solution doesn't usually cover people while they're out of the country except under limited circumstances.
- On the date Medica DUAL Solution coverage begins, I must get my health care from Medica DUAL Solution doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get Medica DUAL Solution approval to see other providers in some circumstances.
- Medica DUAL Solution will cover my health care with Medica DUAL Solution doctors and other providers as outlined in the Member Handbook. I can read the Member Handbook to see what services are covered.
- If I need to see a doctor or other provider who is not in Medica DUAL Solution, I may need prior authorization or I may have to pay out-of-pocket for the services I get.
- I understand that if a sales agent, broker or other individual employed by or contracted with Medica DUAL Solution is helping me, Medica DUAL Solution may pay that person when they enroll me.
- By joining Medica DUAL Solution, I know that Medica DUAL Solution may share my information with Medicare and Medical Assistance (Medicaid) and other plans as necessary for treatment, payment and health care operations.
- 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 request in writing, I will be enrolled in my previous MSC+ plan.
- If I obtain 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.
- 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.
- I know that Medica DUAL Solution may share information including my prescription drug information with Medicare and Medical Assistance (Medicaid). They may release it for research and other purposes, as allowed by Federal statutes and regulations.
- The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from Medica DUAL Solution.
- 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 he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid).

Member Name: ________________________________ Medical Assistance ID #: ________________________

Instructions

For filling out the Medica DUAL Solution Enrollment Form

Please print as neatly as possible. Please fill in the following information by numbered line on your enrollment form.

1	Name:	Write your name (first name, middle initial, last name).
2	Date of birth: Sex:	Write the month, day and year you were born. Check the box indicating if you are male or female.
3	Phone number: Another phone number: Email address:	Write the telephone number where you can be reached during the day. Write another phone number where you can be reached. Write the email address.
4	Address where you live:	Write the permanent address where you live, including street address, city, county, state and ZIP code (no PO boxes).
5	Address where you get mail (if different from where you live):	Write the address where you receive your mail, if different from where you live.
6	Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," check the code of the language needed on the list.
7	Name of the primary care clinic/ care system you are choosing: Code for the primary care provider, clinic or health center you are choosing:	Go to the health plan's *Provider and Pharmacy Directory* in your information packet. Write the name of the primary care provider, clinic or health center that you are choosing. Write the code of the primary care provider, clinic or health center that you chose, located in the *Provider and Pharmacy Directory*.
8	Medicare Number: Hospital (Part A) Effective Date: Medical (Part B) Effective Date:	Take out your Medicare card to complete this section. Write your Medicare number as it appears on your red, white and blue card (not your Social Security card). Write in the effective date for Hospital (Part A) as it appears on your card. Write in the effective date for Medical (Part B) as it appears on your card.
	Member Number: Member Name:	Write in the number as it appears on your Minnesota Health Care Programs card. Write in the name as it appears on your Minnesota Health Care Programs card.
9	Do you have End-Stage Renal Disease (ESRD)?	If you have End-Stage Renal Disease, check "Yes." If you do not, check "No."
10	Do you live in a long-term care facility?	If you now live in a long-term care faciility, such as a nursing home or Intermediate Care Facility for Persons with Developmental Disabilities (ICF-DD), check "Yes." If you do not, check "No."

Member Name: ______________________________ Medical Assistance ID #: ______________________

11	Name of the facility:	If you answered "Yes" to the questions about living in a long-term care facility, write in the name of the facility and their phone number.
12	Do you work? Are you married? Does your spouse work?	If you are currently working, check "Yes." If you are not working, check "No." If you are currently married, check "Yes." If you are not married, check "No." If you checked "Yes" to "Are you married?", check "Yes" if your spouse is currently working. If you are not married, check "No."
13	Do you have other health coverage?	Some people have other health care coverage. If you have other health care coverage, check "Yes." If you do not have other health care coverage, check "No."
14	Name of your plan (and employer, if applicable): Group Number: ID number:	If you have other health care coverage, write in the name of the other plan. If the other health care coverage is through an employer, write in the employer's name. Write in the group number from this plan. Write in your member ID number.

Page C should be singed and filled out by you or your authorized representative.

When the form is completed, mail or fax it to Medica DUAL Solution. Our address and fax number are on the cover.

MEDICA®

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SPP53558-700818A

Member Name: ______________________________ Medical Assistance ID #: ______________________

Medica DUAL Solution® (HMO 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.

Office Use Only:	
Name of Authorized Sales Rep: ______________________	LIS Copay Level: ______________________
ID of Authorized Sales Rep: ______________________	LIS Copay Effective Date: ______________________
Effective Date of Enrollment: ______________________	Approved By: ______________________

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):** **(____) ____ - ______**	**Email address (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 need an interpreter?** ❑ **Yes** ❑ **No** If YES, check correct language below. ❑ 01 Spanish ❑ 02 Hmong ❑ 03 Vietnamese ❑ 04 Khmer (Cambodian) ❑ 05 Lao ❑ 06 Russian ❑ 07 Somali ❑ 08 ASL (American Sign Language) ❑ 10 Arabic ❑ 11 Serbo-Coration/Bosnian ❑ 12 Oromo ❑ 98 Other ______________________			

Member Name: ________________________________ Medical Assistance ID #: ________________________

Tell us where you want to get health care services:

7	**Name of the primary care clinic/care system you are choosing:**	**Primary care clinic/care system provider ID number found in the Provider and Pharmacy Directory.**

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 ID number as it appears on the front of your card.

8	Name as it appears on your Medicare Card: _______________________________________ Medicare Number: ______________________ Is Entitled To Effective Date HOSPITAL (Part A) ____________________ MEDICAL (Part B) ____________________ You must have Medicare Part A and Medicare Part B to join a Medicare Advantage Plan.	**Minnesota Health Care Programs (MHCP)** **Member ID Number:** ____ **Member Name:** ____

Other personal information:

9	**Do you have End-Stage Renal Disease (ESRD)?** ❑ **Yes** ❑ **No** If "yes" and you've had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your doctor.		
10	**Do you live in a long-term care facility?** ❑ **Yes** ❑ **No** If "yes," fill in the information below.		
11	**Name of the facility:**		**Phone number:** (____) ____ - ______
12	**Do you work?** ❑ **Yes** ❑ **No**	**Are you married?** ❑ **Yes** ❑ **No**	**Does your spouse work?** ❑ **Yes** ❑ **No**

Member Name: ________________________________ Medical Assistance ID #: ________________________

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.

<table>
<tr><td rowspan="2">13</td><td colspan="2">Do you have other health coverage? ❑ Yes ❑ No

If “yes,” fill in the information below.</td></tr>
<tr></tr>
<tr><td rowspan="2">14</td><td rowspan="2">Name of your plan (and employer, if applicable):</td><td>Group Number:</td></tr>
<tr><td>ID Number:</td></tr>
</table>

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.

Please read the information on page 6 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