AmeriHealth Caritas
VIP Care

Individual Enrollment Request Form

Please contact AmeriHealth Caritas VIP Care (HMO-SNP) if you need information in another language or format (for example, braille).

TO ENROLL IN AMERIHEALTH CARITAS VIP CARE, PLEASE PROVIDE THE FOLLOWING INFORMATION

Last name:	First name:	Middle initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: | Sex: ☐ M ☐ F

Home phone number: | Alternate phone number:

Permanent residence street address (P.O. Box is not allowed):

City:	County:	State:	ZIP code:

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE ADDRESS)

Street address:

City:	State:	ZIP code:

Emergency contact: | Relationship to you:

Phone number:

Email address:

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your red, white, and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

- OR –

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board (RRB).

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 Part B to join a Medicare Advantage plan.

PAYING YOUR PLAN PREMIUM

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or electronic funds transfer (EFT) each month. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or RRB benefit check each month. If you are assessed a Part D Income-Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan late enrollment penalty. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. **Do not** pay AmeriHealth Caritas VIP Care the Part D IRMAA.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If you are eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a payment option:

☐ Get a bill

☐ Get 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 ☐ Savings	

☐ Credit card. Please provide the following information:

Type of card:	
Name of account holder as it appears on card:	
Account number:	Expiration date (MM/YYYY):

☐ 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 or 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 amounts due 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 late enrollment penalty.)

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.
   Will you have other **prescription** drug coverage in addition to AmeriHealth Caritas VIP Care?
   ☐ Yes ☐ No
   If yes, please list your other coverage and your identification (ID) number(s) for this coverage:
   Name of other coverage: _____
   ID number for this coverage: _____ Group number for this coverage: _____
3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, please provide the following information:
   Name
   of institution: _____
   Address and phone number of institution (number and street): _____
4. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No
   If yes, please provide your Medicaid number: _____
5. Do you or your spouse work? ☐ Yes ☐ No

Please choose the name of a primary care provider (PCP), clinic, or health center:

_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Large print ☐ Chinese ☐ Braille ☐ Other: _____

Please contact AmeriHealth Caritas VIP Care at **1-866-533-5490** if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m.; TTY users should call **711**.

STOP AND READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining AmeriHealth Caritas VIP Care could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AmeriHealth Caritas VIP Care. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

PLEASE READ AND SIGN BELOW

By completing this enrollment application, I agree to the following:

AmeriHealth Caritas VIP Care is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (for example, October 15 – December 7 of every year) or under certain special circumstances. I give the plan permission to contact me by phone to confirm the information on the enrollment application.

AmeriHealth Caritas VIP Care serves a specific service area. If I move out of the area that AmeriHealth Caritas VIP Care serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AmeriHealth Caritas VIP Care, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AmeriHealth Caritas VIP Care when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date AmeriHealth Caritas VIP Care coverage begins, I must get all of my health care from AmeriHealth Caritas VIP Care, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by AmeriHealth Caritas VIP Care and other services contained in my AmeriHealth Caritas VIP Care Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR AMERIHEALTH CARITAS VIP CARE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AmeriHealth Caritas VIP Care, he or she may be paid based on my enrollment in AmeriHealth Caritas VIP Care.

Release of information: By joining this Medicare health plan, I acknowledge that AmeriHealth Caritas VIP Care will release my information to Medicare and other plans as necessary for treatment, payment, and health care operations. I also acknowledge that AmeriHealth Caritas VIP Care will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. 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 my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (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 from Medicare.

Signature: _____ Today's date: _____

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

Name: _____

Address:_____

Phone number:_____ Relationship to enrollee: _____

Office use only:	
Name of staff member, agent, or broker (if assisted in enrollment):	
Plan ID number:	Effective date of coverage:
Application date:	
ICEP/IEP:	SEP (type):
AEP:	MA OEP:
Not eligible:	Other:
NIPR number:	Agent ID:
Agent signature:	Agent writing number: