



An Independent Licensee of the Blue Cross Blue Shield Association

Health
Choice

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 (Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties)

Important: To join this Medicare Advantage Special Needs Plan, you must also have:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicaid (AHCCCS)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Starts 3 months before you get Medicare, the month that you become eligible for Medicare, and 3 months after your Medicare becomes effective
- You're allowed to join or switch plans in certain situations

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 Medicaid (AHCCCS) 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?

Send your completed and signed form to:

By mail: BCBSAZ Health Choice Pathway (HMO D-SNP)
Attn: Enrollment Dept.
410 N. 44th Street, Suite 900
Phoenix, AZ 85008

By fax: 480-760-4635

By email: HCHPathwayEnrollment@azblue.com

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

How do I get help with this form?

Call BCBSAZ Health Choice Pathway at **1-800-656-8991**. TTY users can call **711**, 8 a.m. to 8 p.m., 7 days a week. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

En español: Llame a BCBSAZ Health Choice Pathway al **1-800-656-8991**, TTY: **711**, 8 a.m. to 8 p.m., los 7 días de la semana 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: BCBSAZ Health Choice Pathway – \$0- \$34.40 per month

Name (as it appears on your Medicare card)

FIRST name: _____

LAST name: _____

Middle Initial: _____

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

Sex:

Male

Female

Mobile phone number:

()

Alternate phone number:

()

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

City: _____

State: _____

ZIP Code: _____

County: _____

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

Street address: _____

City: _____

State: _____

ZIP Code: _____

Your Medicare information:

Medicare Number: ____ - ____ - ____

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BCBSAZ Health Choice Pathway? Yes No

Name of other coverage: _____

Member number for this coverage: _____

Group number for this coverage: _____

1. Are you enrolled in your State Medicaid program (AHCCCS)? YES NO

If yes, please provide your Medicaid number: _____

2. 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: _____

Phone Number: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in BCBSAZ Health Choice Pathway.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that BCBSAZ Health Choice Pathway 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).
- I understand that when my BCBSAZ Health Choice Pathway coverage begins, I must get all of my medical and prescription drug benefits from BCBSAZ Health Choice Pathway. Benefits and services provided by BCBSAZ Health Choice Pathway and contained in my BCBSAZ Health Choice Pathway “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BCBSAZ Health Choice Pathway will pay for benefits or services that are not covered.
- 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 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’re the authorized representative (power of attorney),
sign above and fill out these fields:**

Name:

Address:

Phone number:

Relationship to enrollee:

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.**

Select one if you want us to send you information in a language other than English. Spanish

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

- Braille Large print Audio CD

Please contact BCBSAZ Health Choice Pathway at **1-800-656-8991** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users can call **711**.

Do you work? Yes No

Does your spouse work? Yes No

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

Address: _____

By checking this box, I agree to opt in to receive emails and/or texts with information about my enrollment, health programs, and other plan services. I understand I may change my email and text preferences and opt out at any time by calling **1-800-656-8991, TTY: 711**.

I want to get the following materials via email. Select one or more.

- Evidence of Coverage Summary of Benefits Comprehensive Formulary
 Provider Directory Pharmacy Directory Over-the-Counter Catalog

Email address: _____

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.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay BCBSAZ Health Choice Pathway the Part D-IRMAA.

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent/broker number: _____

Date enrollment form was received if mailed/faxed to Agent: _____

Proposed effective date of coverage: _____

AEP ICEP IEP MAOEP SEP

SEP Code (*Required if SEP selected*):

SEP Date:

Paper enrollment:

Telephonic enrollment:

Electronic enrollment:

Pre-Enrollment Checklist



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Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-656-8991, TTY: 711**, 8 a.m. – 8 p.m., 7 days a week.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **HealthChoicePathway.com**, or call **1-800-656-8991, TTY: 711** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure the prescription medicines you use are covered.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/co-insurance may change on January 1, 2024.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

BCBSAZ Health Choice Pathway is a subsidiary of Blue Cross® Blue Shield® of Arizona (BCBSAZ).

Attestation of Eligibility for an Enrollment Period



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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.

<input type="checkbox"/> NEW	I am new to Medicare.
<input type="checkbox"/> OEP	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
<input type="checkbox"/> MOV	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)_____
<input type="checkbox"/> INC	I recently was released from incarceration. I was released on (insert date)_____
<input type="checkbox"/> RUS	I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____
<input type="checkbox"/> LAW	I recently obtained lawful presence status in the United States. I got this status on (insert date)_____
<input type="checkbox"/> MCD	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)_____
<input type="checkbox"/> NLS	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)_____
<input type="checkbox"/> MDE	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.

Attestation of Eligibility for an Enrollment Period



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<input type="checkbox"/> LTC	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/out of the facility on (insert date)_____
<input type="checkbox"/> PAC	I recently left a PACE program on (insert date)_____
<input type="checkbox"/> LCC	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____
<input type="checkbox"/> LEC	I am leaving employer or union coverage on (insert date)_____
<input type="checkbox"/> PAP	I belong to a pharmacy assistance program provided by my state
<input type="checkbox"/> EOC	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
<input type="checkbox"/> OTH	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)_____
<input type="checkbox"/> SNP	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)_____
<input type="checkbox"/> DTS	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.

If none of these statements applies to you or you're not sure, please contact BCBSAZ Health Choice Pathway (HMO D-SNP) at **1-800-656-8991** (TTY users should call **711**) to see if you are eligible to enroll. We are open 8 a.m. – 8 p.m., 7 days a week.

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