



1-877-226-8500 or TTY 1-800-650-2774
7 days a week from 8:00 AM through 8:00 PM

CCM Direct Complete Plan (HMO SNP) Enrollment Form

Please contact Comprehensive Care Management if you need information in another language or format.

To Enroll in Comprehensive Care Management, Please Provide the Following Information:

Direct Complete Plan \$39.70 per month

Last Name: _____ First Name: _____ Middle Initial: _____ Mr. Mrs.
 Ms.

Birth Date: (____/____/____) Sex: M F Home Phone Number: _____ Alternate Phone Number: _____
 (MM/DD/YYYY)

Permanent Residence Street Address: (P.O. Box is not allowed)

City: _____ State: _____ Zip Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ **Phone Number:** _____ **Relationship To You:** _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card
- OR-
- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.



Sample Only

Name: _____

Medicare Claim Number: _____ Sex: _____

Is Entitled To _____ Effective Date _____

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

Paying Your Plan Premium

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 automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT** pay Comprehensive Care Management Direct Complete Plan the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If 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 only pays 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 premium payment option:

Get a bill each month

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/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 premiums 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 premiums.)

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 any more, **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 Comprehensive Care Management? Yes No
If "yes" please list your other coverage and your identification (ID) number(s) for this coverage::

Name of other coverage: _____	ID # for this coverage: _____	Group # for this coverage: _____
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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 & 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 Physician (PCP), clinic or health center:	Are you already a patient of this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please choose the name of a Primary Care Dentist (PCD):	Are you already a patient of this PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Spanish Russian Chinese Korean

Audio tape, large print

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If you currently have health coverage from an employer or union, joining Comprehensive Care Management Direct Complete Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Comprehensive Care Management Direct Complete Plan. 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:

Comprehensive Care Management Direct Complete Plan 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 (Example: October 15 – December 7 of every year), or under certain special circumstances.

Comprehensive Care Management Direct Complete Plan serves a specific service area. If I move out of the area that Comprehensive Care Management Direct Complete Plan 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 Comprehensive Care Management Direct Complete Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Comprehensive Care Management Direct Complete Plan 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 Comprehensive Care Management Direct Complete Plan coverage begins, I must get all of my health care from Comprehensive Care Management Direct Complete Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Comprehensive Care Management Direct Complete Plan and other services contained in my Comprehensive Care Management Direct Complete Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR COMPREHENSIVE CARE MANAGEMENT DIRECT COMPLETE PLAN 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 Comprehensive Care Management Direct Complete Plan, he/she may be paid based on my enrollment in Comprehensive Care Management Direct Complete Plan.

Release of Information: By joining this Medicare health plan, I acknowledge that the Comprehensive Care Management Direct Complete Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Comprehensive Care Management Direct Complete Plan 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: _____

If you are a translator or witness to the enrollment, please provide the following information:

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee: _____

Office Use Only

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

Rep ID:

Plan ID:

Effective Date of Coverage:

ICEP/IEP

OEP

AEP

SEP (type):