

Gateway Health Plan *Medicare Assured*[®] HMO

Instructions to complete the enrollment form.

Please **PRINT NEATLY** on the entire form.

SECTION 1 – INFORMATION ABOUT YOU

This section tells us basic information about you such as your name, address, and phone number. All fields are required. Your Medicare number is called the “Medicare Claim Number” and it is located on your MEDICARE HEALTH INSURANCE identification card.

SECTION 2 –MEDICAID INFORMATION

You must include your Medicaid identification number. If you live in PA, it is the 10-digit recipient number. If you do NOT have MEDICAID benefits, your application will be denied because Gateway Health Plan *Medicare Assured*[®] HMO is a Special Needs Plan that requires you to have Medicare Part A, Part B, and Medical Assistance.

SECTION 3 – MEDICARE INFORMATION

You must complete this section EXACTLY as it appears on your MEDICARE HEALTH INSURANCE identification card. You may attach a copy of your card. If you do not include all of the information in this section, your application cannot be processed.

SECTION 4 – SELECT A PRIMARY CARE PHYSICIAN (PCP)

Please write the name of the Primary Care Physician (PCP) that you want to choose in this section. The PCP must be in our Gateway Health Plan *Medicare Assured*[®] HMO network. You must give us as much information about the PCP as you can, such as the doctor’s first and last name and if he/she belongs to a group practice. For example: John Q. Smith, M.D. – Greater Medical Associates. Include the doctor’s area code and phone number.

SECTION 5 – OTHER INSURANCE INFORMATION

It is very important that you tell us about any other health insurance or prescription drug coverage that you will have in addition to Gateway Health Plan *Medicare Assured*[®] HMO. This includes coverage that you may have on your own, through your spouse, or his/her employer.

SECTION 6 – PLEASE READ AND ANSWER THESE QUESTIONS

1. Check ‘YES’ or ‘NO’ if you have a special kidney disease called End Stage Renal Disease (ESRD).
2. Check ‘YES’ or ‘NO’ if you have ever received a Medicare covered transplant.
(If you checked YES, please provide the date of transplant)

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

This portion of the form requires you to read several Statements of Understanding on the **BACK OF THE ENROLLMENT FORM** to be sure that you understand the terms of participating in Gateway Health Plan *Medicare Assured*[®] *HMO*. You must read and understand those statements and then sign your name and fill in today's date in this section.

If you cannot sign and you have an authorized representative fill out this enrollment form on your behalf, then he/she must sign and date where indicated. Documentation of the authority to act on your behalf must be made available upon request by Gateway Health Plan *Medicare Assured*[®] *HMO* or Medicare.

If anyone helped you fill out this enrollment form, such as a Gateway Health Plan *Medicare Assured*[®] *HMO* Sales Representative or community leader, then he/she must sign and date the form, and specify his/her relationship to you.

IMPORTANT REMINDERS

- Include a copy of your MEDICARE HEALTH INSURANCE identification card.
- IF APPLICABLE, attach a copy of medical notes indicating that you do not need regular dialysis any more or that you had a successful kidney transplant.
- IF APPLICABLE, attach a copy of the legal representative's proof of authorization by state law if someone signs on behalf of the applicant.
- KEEP the yellow copy for your records.
- RETURN the white ORIGINAL to:

Gateway Health Plan *Medicare Assured*[®] *HMO*
US Steel Tower, 41st Floor
600 Grant Street
Pittsburgh, PA 15219-2704
Attn: Enrollment Department



US Steel Tower Floor 41 • 600 Grant Street
 Pittsburgh, PA 15219-2704
 Attn: Medicare Enrollment
 (412) 255-4640 • 1-877-GATEWAY
 7 days a week from 8:00 am to 8:00 pm

ENROLLMENT FORM
GATEWAY HEALTH PLAN
MEDICARE ASSURED® HMO

SECTION 1 – INFORMATION ABOUT YOU (Please print neatly)

Name (First, Middle Initial, Last)		Home Phone (_____) _____ - _____		
Medicare Number _____ - _____ - _____	Date of Birth (month/day/year) ____ / ____ / _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Permanent Residence Address (Number, Street, Apartment)	City	County	State	Zip Code
Mailing Address (Number, Street, Apartment-if different from above)	City	County	State	Zip Code

If you would prefer us to send you information in a language other than English, please check one of these boxes: Spanish Other _____

SECTION 2 – MEDICAID INFORMATION

In order to enroll in Gateway Health Plan *Medicare Assured® HMO*, a Medicare approved Special Needs Plan, you must have Medicare Part A, Medicare Part B and Medical Assistance benefits. If you do not, your application will be denied for lack of coverage.

Please take out your Medicaid identification card to complete this section. Print your recipient # number as it appears on your Medicaid card.

Please take out your Medicare card to complete this section.

- 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 Railroad Retirement Board.

SECTION 3 – MEDICARE INFORMATION

MEDICARE HEALTH INSURANCE	
NAME OF BENEFICIARY _____	
MEDICARE CLAIM NUMBER _____ - _____ - _____	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	____ - ____ - _____
MEDICAL (PART B)	____ - ____ - _____

SECTION 4 – SELECT A PRIMARY CARE PHYSICIAN

Print the name and phone number of your chosen Primary Care Physician (PCP), clinic or health center.

Name: _____ Phone: (_____) _____ - _____

SECTION 5 – OTHER INSURANCE INFORMATION

Some individuals may have other coverage including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you, on your own or through your spouse, have any health insurance or prescription drug coverage other than Medicare? Yes No
If “yes”, please print the name and policy number for any insurance that you have other than Medicare, Medigap, or Medicaid (Access):

Insurance Company Name: _____ Policy Number: _____

SECTION 6 – PLEASE READ AND ANSWER THESE QUESTIONS

1. Do you have End Stage Renal Disease (ESRD)? Yes No
ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. **Note:** If you have ESRD, you cannot enroll in this plan. If you do not need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor.

2. Have you ever received a Medicare covered transplant? Yes No If yes, date of transplant: ____ - ____ - ____

STATEMENTS OF UNDERSTANDING AND AUTHORIZATION

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where I live) on this application means that I have read and understand the contents of this application including the *Statements of Understanding* on the BACK OF THIS FORM. 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 by Gateway Health Plan *Medicare Assured*® HMO or by Medicare.

Your Signature: X _____ Date: _____

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

Name: _____ Relationship to Enrollee: _____

Address: _____ Phone: (____) _____ - _____

FOR INTERNAL USE ONLY

Field representative signature: _____ Adjudicator _____

Tracking # _____ Proposed Effective Date: ____ - ____ - ____

Section reserved for Medicare Process Administration Department

STATEMENTS OF UNDERSTANDING

Your signature on the other side of this form means that you agree to the following:

1. I can be in only one Medicare Advantage plan at a time. My enrollment in Gateway Health Plan *Medicare Assured*[®] *HMO* will automatically end my enrollment in any other Medicare health plan or prescription drug plan that I am currently in. I do not need to enroll in a separate Prescription Drug Plan (PDP).
2. I will need to keep Medicare Part A and Part B. It is my responsibility to tell Gateway Health Plan *Medicare Assured*[®] *HMO* of any prescription drug coverage that I have or may get in the future.
3. Gateway Health Plan *Medicare Assured*[®] *HMO* serves a specific service area. If I move out of the Gateway Health Plan *Medicare Assured*[®] *HMO* service area, I need to tell Gateway Health Plan *Medicare Assured*[®] *HMO* so I can disenroll and find a new plan in my new area. I understand that people with Medicare aren't usually covered under Medicare while out of the country.
4. I will read my Evidence of Coverage document from Gateway Health Plan *Medicare Assured*[®] *HMO* when I receive it, to know which rules I must follow in order to receive coverage with this plan.
5. Once I am a member of Gateway Health Plan *Medicare Assured*[®] *HMO*, I have the right to appeal plan decisions about payment or services if I disagree.
6. **Lock-In:** I understand that, beginning on the date my Gateway Health Plan *Medicare Assured*[®] *HMO* coverage begins, I must get all of my prescription drugs and all of my health care from Gateway Health Plan *Medicare Assured*[®] *HMO*, except for emergency or urgently needed services or out-of-area dialysis services. Services contained in my Gateway Health Plan *Medicare Assured*[®] *HMO* Evidence of Coverage document and other medically authorized services authorized by the plan will be covered. Without authorization, **NEITHER MEDICARE NOR GATEWAY HEALTH PLAN *Medicare Assured*[®] *HMO* WILL PAY FOR THE SERVICES.**
7. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Gateway Health Plan *Medicare Assured*[®] *HMO*, he/she may be compensated based on my enrollment in Gateway Health Plan *Medicare Assured*[®] *HMO*.
8. **Release of Information:** By joining Gateway Health Plan *Medicare Assured*[®] *HMO*, I acknowledge that Gateway Health Plan *Medicare Assured*[®] *HMO* will release my information to Medicare and other plans, medical providers, or other entities as is necessary for treatment, payment and health care operations. I also acknowledge that Gateway Health Plan *Medicare Assured*[®] *HMO* 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.
9. 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.