

SOUTH COUNTRY

HEALTH ALLIANCE

Bringing Wellness Home

110 West Fremont Street

Owatonna, MN 55060

Fax: 507-431-6328

AbilityCare

South Country Health Alliance Member Services

1-866-567-7242 (Toll Free)

TTY for the hearing impaired at 1-877-824-5611 or

1-877-627-3848 (speech to speech relay service)

8:00 a.m. – 8:00 p.m., seven days a week

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយកម្រៃឥតមាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງໂທສຕາມເລກໂທສທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeoyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

185-0013 (10-09)

This information is available in other forms to people with disabilities by calling **1-866-567-7242** (toll free) or **1-877-824-5611** (TTY for the hearing impaired), or 711, or through the Minnesota Relay at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).


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 enrollees 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.

South Country Health Alliance is a Medicare Advantage organization with a Medicare contract.

Member Name: _____ Medical Assistance # _____

<p>Office Use Only: Date _____ Tracking # _____ Name of Authorized Sales Person _____ _____ Effective Date of Enrollment _____ LIS Co-Pay Level _____ LIS Co-Pay Eff Date _____ Approved By _____</p>
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AbilityCare (HMO SNP) Enrollment Form

1	Last Name	First Name	M.I.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
2	Birth Date: (__ / __ / ____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Phone Number: () _____	
3	Permanent Residence Street Address (P.O. Box is not allowed): _____ _____			
	City:	State:	Zip Code:	
4	Mailing Address (only if different from your Permanent Residence Street Address above): _____ _____			
	City:	State:	Zip Code:	
5	County of Residence:			
If you have Medicare, please provide your Medicare Insurance information				
6	If you have Medicare, you must have Medicare Part A and Part B to join a Medicare Advantage plan. Please take our your Medicare card to complete this section. <ul style="list-style-type: none"> 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 Social Security or the Railroad Retirement Board. 	 <p style="text-align: center;">SAMPLE ONLY</p> Name: _____ Medicare Claim Number _____ Sex _____ _____ - _____ - _____ Is Entitled To _____ Effective Date _____ Hospital (Part A) _____ Medical (Part B) _____		
7	Please provide your Medical Assistance ID number (it is on your Minnesota Health Care Programs card):			
8	Are you a resident in a long-term care facility such as a nursing home or ICF-MR? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the following information: Name of Institution: _____			

Member Name: _____ Medical Assistance # _____

9	Primary Care Clinic you are choosing:	Primary Care Clinic # found the Provider Directory or Primary Care Network Listing:				
10	Race (optional) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Black or African American					
11	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," circle correct language					
	01 Spanish 07 Somali	02 Hmong 08 ASL (American Sign Language)	03 Vietnamese 10 Arabic	04 Cambodian 11 Bosnian-Serbo-Croatian	05 Laotian 12 Oromiffa	06 Russian 98 Other _____ _____
12	Please read and answer these important questions:					
<p>1. Do you have a medical spenddown? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Do you have End Stage Renal Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes" to this question and you don't need regular dialysis any more or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.</p> <p>4. Do you or your spouse have health insurance through a previous or current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Employer Name _____ Policy Holder Name _____ Policy # _____</p> <p>5. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits. Will you have other prescription drug coverage in addition to AbilityCare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other Coverage _____ Policy ID# for this Coverage _____ Group# for this Coverage _____</p>						



Please Read This Important Information

If you currently have health coverage from an employer or union, joining AbilityCare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join AbilityCare. 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 on page 5

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

- South Country Health Alliance (SCHA) AbilityCare is a Medicare Advantage plan and has a contract with the Federal government.
- AbilityCare will be providing coverage for my care covered by Medicare and Medical Assistance or only Medical Assistance if I do not have Medicare.
- I can be in only one (1) 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 the plan of any prescription drug coverage that I have or may get in the future.
- To be enrolled and stay enrolled in AbilityCare, I must:
 - be at least 18 and under age 65 at the time of enrollment;
 - Have a certified disability through the Social Security Administration or the State Medical Review Team
 - receive Medical Assistance with or without Medicare Parts A and B; and
 - live in the AbilityCare service area.If any of this changes, I will notify AbilityCare so I can disenroll and find a new plan.
- I can choose to leave AbilityCare at any time. I understand that I will be enrolled in AbilityCare through the last day of the month.
- Once I am a member of AbilityCare, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the **Certificate of Coverage** from AbilityCare 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 AbilityCare coverage begins, I must get all of my Medicare-covered health care from AbilityCare network providers. If I don't, **NEITHER MEDICARE NOR ABILITYCARE WILL PAY FOR THE SERVICES**. Exceptions to this rule are emergency care, urgently needed services, **open access** services, out-of-network dialysis services, or any other services previously authorized. Services authorized by AbilityCare and other services contained in my AbilityCare **Certificate of Coverage** will be covered.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with AbilityCare, he/she may be paid based on my enrollment in AbilityCare.
- If I obtain a medical spenddown while enrolled in AbilityCare and do not pay it to DHS, I will be disenrolled from AbilityCare.

Member Name: _____ Medical Assistance # _____

- **Release of information:** By joining AbilityCare, I acknowledge that:
- AbilityCare will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
- AbilityCare 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.
- By enrolling in AbilityCare, I authorize the State to give information about my Medicare and Medical Assistance status and the information on this form to its representatives, the county where I live now, and to South Country Health Alliance.
- 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 AbilityCare.

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 by State law to complete this enrollment form, and
2. Documentation of this authority is available upon request by AbilityCare or by Medicare.

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

INSTRUCTIONS

For filling out the AbilityCare Enrollment Form

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

1	Name	Write your name (Last name, first name, middle initial).
2	Birth date Sex Primary phone number	Write the month, day, and year you were born. Check the box indicating if you are male or female. Write the telephone number where you can be reached during the day
3	Permanent residence street address	Write in the permanent address where you live, including street address, city, state, and zip code (no P.O. boxes).
4	Mailing address	Write in the address where you receive your mail, if different from your permanent street address.
5	County of Residence	Write in the county where you live.
6	Medicare Number Effective Date Hospital (Part A) Effective Date Hospital (Part B)	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 Hospital (Part B) as it appears on your card.
7	Medical Assistance	Write in your Medical Assistance number.
8	Are you a resident in a long-term care facility?	If you now live in a long-term care facility, such as a nursing home or ICF-MR, check "Yes" and write in the name, address, and phone number. If you do not, check "No."
9	Primary Care Clinic Primary Care Clinic #	Go to the South Country Primary Care Network Listing or Provider Directory in your information packet. Write in the primary care clinic that you choose. Write the code of the primary care clinic that you choose, located in the Primary Care Network Listing or Provider Directory.
10	Race (Optional):	Check the box indicating your race.
11	Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," circle the code of the language needed on the list.
12	1. Medical Spenddown 2. Certified Disability 2. End Stage Renal Disease 3. Health Insurance through an Employer: 4. Other prescription drug Coverage:	Check "Yes" or "No." Check "Yes" or "No." Check "Yes" or "No." If you answered "Yes" to this question, please fill out the employer name, policy holder's name, and policy number. If you answered "Yes" to this question, please fill out the name of the other coverage, the ID number, and Group number.