

CareSource Advantage (HMO) Individual Enrollment Request Form

Please contact CareSource if you need information in another language or format (Braille).

To Enroll in CareSource Advantage, Please Provide the Following Information:

LAST name:	FIRST name:	Middle initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (____/____/____) (MM / DD / YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (____)____-____	Alternate Phone Number: (____)____-____

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: _____
Phone Number: (____)____-____ Relationship to You: _____

E-mail Address: _____

Please Provide Your Medicare Insurance Information

<p>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 Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage Plan.</p>	Name: _____ Medicare Claim Number: _____ Sex: ____ ____-____-____ Is Entitled To: _____ Effective Date: _____ HOSPITAL (Part A): _____ MEDICAL (Part B): _____
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Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes 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.

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 CareSource Advantage? 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: _____

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. You must have Medicaid coverage to join the CareSource Medicare Advantage Special Needs Plan. Are you enrolled in your State Medicaid program? Yes No
If "yes", please provide your Medicaid Recipient 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 Read The Important Information On The Reverse Side Before Signing

***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:** _____

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, Somali, Arabic, or _____ Other _____
- Braille, audio tape or large print

Please contact CareSource Advantage at 1-877-725-4581 (TTY users should call 1-800-649-3777 or 711) if you need information in another format or language than what is listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m.

STOP - Please Read This Important Information

If you currently have health coverage from an employer or union, joining CareSource Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join CareSource Advantage. 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 The Important Information Below Before Signing This Enrollment Form

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

CareSource Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B, and my Medicaid coverage. 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: November 15 – December 31 of every year), or under certain special circumstances.

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

Release of Information: By joining this Medicare health plan, I acknowledge that CareSource will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. *I also acknowledge that CareSource 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 by CareSource Advantage or by Medicare.

Office Use Only: _____ Date Received

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

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

CareSource Advantage
P.O. Box 807
Dayton, OH 45401-0807

Toll-free phone: 1-877-725-4581
(TTY: 1-800-649-3777 or 711)
Web: www.caresource.com