

BlueAdvantage PFFSSM Medical Only
Enrollment Request Form
Basic and Classic Options

Unfold the enrollment request form and print clearly with a black ball point pen.

- **Press hard enough so that your writing appears on the yellow copy.**
- **Be sure to complete all required fields and answer all questions.**
- **Sign and date the third page of the enrollment form.**
- **Remove the yellow copy and keep it for your records.**
- **Mail the enrollment request form in the envelope provided. Or to the address below:**

BlueCross BlueShield of Tennessee
Attention: BlueAdvantage Enrollment
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402-0005

Fax Number: 423-535-8846



A health plan with a Medicare contract.

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This document has been classified as confidential

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 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. Do you or your spouse work? Yes No

Please check one of the boxes below if you would prefer that we send you information in another format:

Audio Tape CD

Please contact BlueAdvantage PFFS at 1-800-841-7434 (TTY users should call TTY: 1-888-423-9490) if you need information in another format than what is listed above.

Our office hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 1 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.



Please Read This Important Information

BlueAdvantage PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn’t required to agree to accept our plan’s terms and conditions and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept BlueAdvantage PFFS before each visit. Providers can find the plan’s terms and conditions on our Web site at www.bcbst.com/providers/BenefitHighlights.shtml.

Once BlueAdvantage PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in BlueAdvantage PFFS. If BlueAdvantage PFFS isn’t able to reach you by telephone, then you will get a letter by mail that contains similar information.

Please Read and Sign Below

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

BlueAdvantage PFFS is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. I understand that since this plan does not offer Medicare prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don’t have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare’s), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage 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 if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private Fee-for-Service plan, BlueAdvantage PFFS works differently than a Medicare supplement plan as well as other Medicare Advantage plans. BlueAdvantage PFFS pays instead of Medicare, and I will be responsible for the amounts that BlueAdvantage PFFS doesn’t cover, such as copayments and coinsurances. Original Medicare won’t pay for my health care while I am enrolled in BlueAdvantage PFFS.

Before seeing a provider, I should verify that the provider will accept BlueAdvantage PFFS. I understand that my health care providers have the right to choose whether to accept BlueAdvantage PFFS’s payment terms and conditions every time I see them. I understand that if my provider doesn’t accept BlueAdvantage PFFS, I will need to find another provider that will.

BlueAdvantage PFFS serves a specific service area. If I move out of the area that BlueAdvantage PFFS serves, I need to notify BlueAdvantage PFFS so I can disenroll and find a new plan in my new area. Once I am a member of BlueAdvantage PFFS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueAdvantage PFFS when I get it to know which rules I must follow to get coverage with this Private Fee-for-Service 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 if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueAdvantage PFFS, he/she may be paid based on my enrollment in BlueAdvantage PFFS.

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

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you don't add or drop your prescription drug coverage (i.e. if you have Medicare prescription drug coverage, you can only change to another plan with Medicare prescription drug coverage; if you don't have Medicare prescription drug coverage, you can only change to another plan without Medicare prescription drug coverage). Additionally, there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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.

- I am making my annual enrollment period election (Nov. 15 - Dec. 31).
- I am making my annual open enrollment period election (Jan. 1 - Mar. 31).
- I am new to Medicare.
- 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): _____.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.

- I no longer qualify for extra help paying for my Medicare prescription drugs.
I stopped receiving extra help on (insert date): _____.
- 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): _____.
- I recently left a PACE program on (insert date): _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).
I lost my drug coverage on (insert date): _____.
- I am leaving employer or union coverage on (insert date): _____.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
I returned to the U.S. on (insert date): _____.
- None of these statements applies to me.*

**Please contact BlueAdvantage PFFS at 1-800-292-5146 (TTY users should call 1-877-664-6422) to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 1 to September 30, you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.*

Office Use Only

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

Plan ID #: _____ Effective Date of Coverage: _____

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

Licensed Agent Use Only

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent: _____ Agent ID #: _____ Date Received: _____

Agent Signature: _____

SOA: Yes No

If "Yes," attach form or enter Reference #: _____