BlueEssential (HMO SNP)℠ Pre-Enrollment Qualification Assessment Tool

Submit this form with the enrollment application for the BlueEssential plan.

Applicant to Complete

First Name:	Middle Initial: (Optional)	Last Name:
Medicare Beneficiary Number:	Date of Birth:	Phone:
Address:		
City:	State:	ZIP Code:

Clinical Qualifying Question

You may be eligible to join the BlueEssential Chronic Condition Special Needs Plan (CSNP) if you have been diagnosed with diabetes and/or cardiovascular disease. Before the end of the first month of enrollment, we'll attempt to confirm with the provider(s) listed below that you have one of the conditions necessary for enrollment. If we can't verify the chronic condition(s) with your provider(s), you will no longer be eligible for the BlueEssential plan. We'll have to disenroll you.

Medical Questions

Question			
1. Have you been diagnosed with diabetes?	Yes	No	Not Sure
2. Have you had problems with high blood sugar?	Yes	No	Not Sure
3. Do you take medication and/or have you been put on a special diet to control your blood sugar?	Yes	No	Not Sure
4. Have you been diagnosed with hypertension (high blood pressure)?	Yes	No	Not Sure
5. Have you been diagnosed with coronary heart disease (heart attack, clogged arteries, stents, stroke, heart surgery)?	Yes	No	Not Sure
6. Have you been diagnosed with peripheral vascular disease (poor circulation)?	Yes	No	Not Sure
7. Have you been diagnosed with chronic venous thromboembolic disorder (blood clots)?	Yes	No	Not Sure

Applicant's Authorization to Disclose Health Information to Verify Chronic Condition(s)

I authorize the provider(s) listed below to share my health information with BlueEssential Special Needs Plan to verify that I have a chronic condition that makes me eligible for enrollment in this plan. This authorization applies to health information maintained by the provider(s) about my medical history for the chronic condition(s) identified on the first page. Information shared by this provider will be protected by BlueEssential by applicable state and federal laws and requirements.

Health care provider(s) who can verify your chronic condition(s)

Provider Name:	Provider Phone:	Provider Fax: (Optional)
Provider Address:		

Use if needed

Provider Name:	Provider Phone:	Provider Fax: (Optional)
Provider Address:		

Printed Applicant Name	Applicant Initials	Initial Date

1 Cameron Hill Circle | Chattanooga, TN 37402

If you should have any questions about this form, please contact Sales Support at **1-888-665-5678,** TTY **711.** From **Oct. 1 to March 31,** you can call us from 8:00 a.m. to 9:00 p.m. ET seven days a week. From **April 1 to Sept. 30,** we're available from 8:00 a.m. to 9:00 p.m. ET Monday through Friday. If you call us outside these hours or on a holiday, our automated system will answer your call. You can leave a message for us, and we will call you back the next business day.

BlueCross BlueShield of Tennessee, Inc., and SecurityCare of Tennessee, Inc., Independent Licensees of the Blue Cross Blue Shield Association. SecurityCare of Tennessee does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-851-2583, TTY 711

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-888-851-2583, TTY 711.

2021 BlueEssential (HMO SNP)℠ Enrollment Request Form

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

To Enroll in BlueEssential, Please Provide the Following Information:

Please check which plan you want to enroll in:

- ❑ BlueEssential NE
- ❑ BlueEssential SE
- ❑ BlueEssential W
- ❑ BlueEssential M

Last Name:	**First Name:**	**Middle Initial:**	❑ **Mr.** ❑ **Mrs.** ❑ **Ms.**
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	**Sex:** ❑ M ❑ F	**Home Phone Number:** ( )	Alternate Phone Number: ( )

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

City:	**County:**	**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

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  -OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

____

Medicare Number: ______________________________

Is Entitled to:	Effective Date:
HOSPITAL (Part A)	______________
MEDICAL (Part B)	______________

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

BlueCross BlueShield of Tennessee, Inc., and SecurityCare of Tennessee Inc., Independent Licensees of the Blue Cross Blue Shield Association. BlueEssential is an HMO SNP plan with a Medicare contract. Enrollment in BlueEssential depends on contract renewal.

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) 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 the RRB. DO NOT pay BlueCross BlueShield of Tennessee 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 coinsurance. 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 pays only 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
- ☐ Electronic funds transfer (EFT) from your bank account each month.
  Please provide the following:
  Account holder name: ______________________ Bank routing number: |_|_|_|_|_|_|_|_|_|
  Bank account number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Account type: ☐ Checking ☐ Saving
  If you select EFT, your first month's premium will be deducted from your banking account at the time CMS accepts your enrollment.
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

  I get monthly benefits from: ☐ Social Security ☐ RRB

  (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. 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 BlueEssential?
   ❑ 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: ____________________

2. 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): ____________________

3. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

   If "yes," please provide your Medicaid number: ____________________

4. Do you or your spouse work? ❑ Yes ❑ No

5. Do you have diabetes and/or cardiovascular disease? ❑ Yes ❑ No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

Doctor's Name: ____________________

Doctor's Address: ____________________

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

❑ Spanish welcome packet

❑ Digital welcome packet **(Email address is required on page 1 to receive digital file.)**

Please contact BlueEssential at **1-888-851-2583** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 9 p.m. ET, 7 days a week. Our automated phone system may answer your call during weekends and holidays from **April 1 - Sept. 30.** Please leave your name and telephone number, and we'll call you back by the end of the next business day. TTY users should call **711**.

Note: Email communications are not secure, so there is a possibility that information included in emails can be intercepted or read by someone else. By providing your email address, you accept the risks associated with emailing.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining BlueEssential could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BlueEssential. 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:

BlueEssential 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.

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

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

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):________________________

Plan ID #:____________________________

Effective Date of Coverage: ______________

ICEP/IEP: ______ 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 enrollee.

Licensed Agent:____________________ Agent ID #:__________________ Date Received:____________

Agent Signature:____

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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 new to Medicare.
- ❑ I am making my annual enrollment period election (October 15 through December 7).
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently was released from incarceration. I was released on (insert date) ______________________.
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________.
- ❑ I recently obtained lawful presence status in the United States. I got this status on (insert date) ______________________.
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ______________________.
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ______________________.
- ❑ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ❑ 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.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ______________________.
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ______________________.
- ❑ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ❑ None of these statements apply to me. Please contact BlueAdvantage (PPO) at **1-800-292-5146** (TTY users should call **711**) to see if you are eligible to enroll. From **Oct. 1** to **March 31,** you can call us from 8 a.m. to 9 p.m. ET, 7 days a week. From **April 1** to **Sept. 30,** we're available from 8 a.m. to 9 p.m., ET, Monday through Friday. If you call us outside these hours or on a holiday, our automated system will answer your call. You can leave a message for us, and we will call you back the next business day.

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