

2023 BlueAdvantage (PPO)<sup>SM</sup>

# Enrollment Request Form

**1 Who can use this form?**

People with Medicare who want to join a Medicare Advantage Plan must:

- ✓ Be a United States citizen or be lawfully present in the U.S.
- ✓ Live in the plan's service area
- ✓ Also have both: Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)

**2 When do I use this form?**

- Between **October 15–December 7** each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

**Reminders:**

To join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by **December 7**.

Your plan will send you a bill for the plan's premium. You can choose how you want your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

**3 What do I need to complete this form?**

- Your red, white, and blue Medicare card number
- Your permanent address and phone number
- You must complete all items in Section 1. Section 2 is optional — you can't be denied coverage because you don't fill it out.

**4 How do I get help with this form?**

- Call BlueAdvantage at **1-800-292-5146**. TTY users can call **711**.
- En español: Llame a BlueAdvantage al **1-800-292-5146**, TTY **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para para asistirle.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, TTY **1-877-486-2048**.
- Visit **Medicare.gov** to learn more about when you can sign up for a plan.

**5 What happens next?** Send this completed and signed enrollment form to:

BlueCross BlueShield of Tennessee | ATTN: Medicare Advantage Enrollment  
1 Cameron Hill Circle, Suite 0006 | Chattanooga, TN 37402-0006

Once we process your enrollment request form, we'll contact you.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**IMPORTANT:** Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.



**Section 1 – All fields on this page are required (unless marked optional)**

**Select the BlueAdvantage plan you want to join:**

- Sapphire N GA (PPO) - \$0 per month

Your Medicare number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
 First name Last name Middle initial (OPTIONAL)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Birth date (MM/DD/YYYY) Sex:  Female  Male (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
 Phone number

Permanent residence street address (PO BOX NOT ALLOWED)

\_\_\_\_\_  
 City County State ZIP code

Mailing address, if different from your permanent address (PO BOX ALLOWED)

\_\_\_\_\_  
 City County State ZIP code

**Answer this important question:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to BlueAdvantage?

- Yes (If Yes, you must provide the information below.)
- No

\_\_\_\_\_  
 Name of other coverage Member number for this coverage Group number for this coverage



**IMPORTANT — Read and sign below:**

- ✓ I must keep Hospital (Part A) and Medical (Part B) to stay in BlueAdvantage.
- ✓ By joining this Medicare Advantage Plan, I acknowledge that BlueAdvantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement on page 5).
- ✓ Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- ✓ 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- ✓ I understand that when my BlueAdvantage coverage begins, I must get all of my medical and prescription drug benefits from BlueAdvantage. Benefits and services provided by BlueAdvantage and contained in my BlueAdvantage “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor BlueAdvantage will pay for benefits or services that are not covered.
- ✓ I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Signature Today's date

**If you're the authorized representative, sign above and fill out these fields:**

\_\_\_\_\_(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
 Name Phone number Relationship to enrollee

\_\_\_\_\_  
 Street address City State ZIP code



**Section 2 – All fields on this page are optional. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

**1 Are you Hispanic, Latino/a, or Spanish origin? Select one.**

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino/a, or Spanish origin
- I choose not to answer.

**2 What's your race? Select one.**

- American Indian or Alaska Native
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- White
- I choose not to answer.

**3  Yes, I would like to receive my welcome packet via email.**

- Yes, I would like to receive my materials via email when available.

**Select one or more:**

- Annual Notice of Change (ANOC)
- Care Management
- Benefits & Coverage Information
- Claims Information
- Wellness Tips & Checkup Reminders

E-mail address: \_\_\_\_\_

Please contact BlueAdvantage at **1-800-831-2583** if you need information in an alternate format other than what's listed above. Our office hours are 8 a.m. to 9 p.m. ET, seven 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 can call **711**.

**4  Yes, I would like to receive available communications via text.**

Mobile phone number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Note:** By checking the above boxes I agree to enroll in email and/or mobile text communication service, and that I am 18 or older, or the legal guardian or personal representative of the applicant. BlueCross, its affiliates and its service providers may send me email and/or text communications that also go out to other members at the same time. Unencrypted email or text messages may possibly be intercepted and read by people other than those it's addressed to. By providing my email address, I accept the risks associated with emailing. Message and data rates may apply.

**5 List your Primary Care Provider (PCP), clinic, or health center:**

Provider's name: \_\_\_\_\_

Provider's address: \_\_\_\_\_

**6 Do you or your spouse work?  Yes  No**



# 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 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.
- I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.
- None of these statements apply to me.

Please contact **BlueAdvantage** at **1-800-292-5146**, TTY **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. BlueAdvantage is a PPO Plan with a Medicare contract and BlueCare Plus is an HMO D-SNP with Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueAdvantage and BlueCare Plus depends on contract renewal. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association