

DHS Oregon Department of Human Services
Health Services
Office of Medical Assistance Programs

**Information
Memorandum
Transmittal**

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Number: OMAP-IM-05-090

Issue Date: 07/01/2005

Authorized Signature

Topic: Medical Benefits

Subject: Announcements to affected dual eligible clients:
① informing them that their OMAP Medical Plans are contracting with Medicare as Medicare Advantage Plans, and
② providing an enrollment form, return envelope and instructions

Applies to: DHS staff and others identified on the SPD, CAF, OMHAS and OMAP transmittal lists

Message:

OMAP is mailing announcements to dual eligible clients (clients with both Medicaid and Medicare coverage) who are enrolled in Medical Plans that are now contracting with Medicare as Medicare Advantage Plans. The Medical Plans and their Medicare Advantage Plan names are listed below.

Medical Plan	Medicare Advantage Plan
Cascade Comprehensive Care (CCC).....	ATRIO Health Plan
Doctors of the Oregon Coast South (DOCS).....	ATRIO Health Plan
Douglas County IPA (DCIPA)	ATRIO Health Plan
Intercommunity Health Network (IHN)	Samaritan Advantage Health Plan
Mid-Rogue IPA (MRIPA)	CareSource

In addition to informing clients that their Medical Plan also contracts as a Medicare Advantage Plan, the announcement explains the benefits of enrolling in the Medicare Advantage Plan and includes an enrollment form and return envelope, for those who choose to enroll.

A sample notice and the enrollment form are included in this transmittal.

If you have any questions about this information, contact:

Contact(s):	Patricia Roller, MMA Coordinator, OMAP	
Phone:	(503) 947-5128	
E-mail:	Patricia.Roller@dhs.state.or.us	Fax:

This information is for any member of your household who has **both** Medicare and Medicaid (Oregon Health Plan) coverage.

Your current OMAP Medical Plan, Intercommunity Health Network (IHN), is contracting with Medicare to also become a Medicare Advantage Plan called Samaritan Advantage Health Plan. If you enroll in Samaritan Advantage Health Plan it will **not** change your health care coverage, it will just change who pays (Medicaid or Medicare) for some of your covered services.

You Have a Choice

- If you want to enroll in Samaritan Advantage Health Plan:
 - ✓ Fill out the *Medicare Advantage Plan Election form* enclosed with this announcement. Write Samaritan Advantage Health Plan as the name of the Medicare Advantage Plan you are choosing.
 - ✓ Sign and mail the form, using the envelope we've included, **by July 15, 2005**.

Samaritan Advantage Health Plan will send you information about itself and tell you when your membership begins.

Being enrolled in both IHN and Samaritan Advantage Health Plan will make it easier to coordinate your health care and make sure you receive all of the services covered by Medicare **and** the Oregon Health Plan.

- If you do not complete and return the *Medicare Advantage Election Form* you will not be enrolled in Samaritan Advantage Health Plan. **However, IHN may decide not to provide Oregon Health Plan (OHP) medical coverage for you anymore.**

If IHN does not provide your OHP medical coverage, the Office of Medical Assistance Programs will help you enroll in a new OMAP Medical Plan or pay for all of your other covered health services on a fee-for-service basis, by having you go to any provider who will take your OMAP Medical Care ID.

Questions?

- ☎ If you have any questions about this information, call IHN. The phone number is listed in field 8a on your OMAP Medical Care ID.
- ☎ If you need this information in a larger print size or different format, call your worker.
- ☎ If you need help filling out the *Medicare Advantage Plan Election form*, call 1-877-585-0007.



Medicare Advantage Election Form

IMPORTANT INFORMATION

Please write in the name of the plan:	Your Primary Care Provider: (Please include FIRST and LAST Name)
Do you have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have you received a kidney transplant within the last 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note: If you have ESRD, you cannot enroll in the Medicare Advantage plan unless you are already enrolled in the plan as a Commercial member.)	

PERSONAL INFORMATION

Name (Last) _____ (First) _____ (Middle Init.) _____		
Birthdate (m/d/y)	M/F	Telephone No.: _____
Social Security No.: _____		Medicare No.: _____
Your Permanent Residence Address:		
Number: _____	Street: _____	Apt. No.: _____
City: _____	County: _____	State: _____ ZIP Code: _____

Are you currently a resident in an institution such as a nursing facility, foster care home or residential care, or assisted living facility? *Note: Your answer to this question will not affect your eligibility to enroll in the Medicare Advantage plan.* No Yes

If yes, Institution Name: _____

Address: _____

Phone No.: _____ Your Date of Admission _____

Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, Workers Compensation, or VA Benefits?

No Yes - If yes, what kind of coverage do you have? _____

Name of Insurance: _____

<p style="text-align: center;">Medicare Information</p> <p>Please fill in the blanks to the right, with the information on your Medicare card. This information must be filled out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. We cannot consider this election form "complete" until we have obtained this information.</p>	<p style="text-align: center;">Medicare Health Insurance Social Security Act</p> <p>Name of Beneficiary: _____</p> <p>Medicare Claim Number: _____ Sex: M F</p> <p>Is Entitled to: _____ Effective Date: _____</p> <p><input type="checkbox"/> Hospital Insurance (Part A) _____</p> <p><input type="checkbox"/> Medical Insurance (Part B) _____</p>
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Prime No.:	Branch No.:	Worker ID/Phone No.:	OHP Plan Effect. Date:	Date Mailed to Plan
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**Please read each of the following statements and
put your initials next to the statements.**

1. I understand that the plan will be sending me final confirmation of my enrollment in the Medicare Advantage plan.

_____ (Initials)

2. I understand I must maintain my Medicare Part A and Part B insurance. The State of Oregon will continue to pay the Part B premiums and the Part A premiums, if applicable.

_____ (Initials)

3. I understand that I can be a member of only one Medicare Advantage plan at a time. By enrolling in the Medicare Advantage plan on this form, I will automatically be disenrolled from any other Medicare Advantage plan of which I am currently a member.

_____ (Initials)

4. I also understand that since I can be a member of only one Medicare Advantage plan at a time, I cannot enroll in more than one Medicare Advantage plan with the same effective date of coverage. If I do this, my enrollments will be canceled and I will have to fill out a new enrollment form to become a member of a Medicare Advantage plan.

_____ (Initials)

5. I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan, the Social Security Office, or the Railroad Retirement Board. Until the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan provider.

_____ (Initials)

6. I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

_____ (Initials)

7. I understand that it is my responsibility to inform the Medicare Advantage plan before permanently moving out of the service or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the Medicare Advantage plan to disenroll me.

_____ (Initials)

Release of Information

By enrolling in the Medicare Advantage plan, I authorize the Centers for Medicare and Medicaid Services (CMS) to provide information to the Medicare Advantage plan I have selected confirming my entitlement to Medicare Hospital Insurance Benefits (Part A) and to Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

Lock-In

I understand that beginning on the date my Medicare Advantage plan coverage begins I must receive all of my health care from the Medicare Advantage plan with the exception of emergency or urgently needed out-of-area services. In addition to being covered in the United States, emergency and urgently needed out-of-area services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare Advantage plan and other services contained in my Medicare Advantage plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

I ALSO UNDERSTAND THAT WITHOUT AUTHORIZATION, NEITHER MEDICARE NOR THE MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

I understand that my signature on this application certifies that I have read and understand the contents of this application. Once I am enrolled into a Medicare Advantage plan, I will receive the Medicare Advantage plans Evidence of Coverage document with a written copy of the rules I must follow in order to receive coverage under this Medicare Advantage plan contract.

Enrollee's Signature: _____ Date: _____

If the beneficiary is unable to sign, a court-appointed Legal Guardian or person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, or other, if authorized by state law, must complete the next page.

If the beneficiary signs with their mark or stamp, two witnesses must sign on the next page.

For State-Approved Signatures or Signature by Mark

Complete this form when anyone other than the client signs the Medicare Advantage Election Form or if the client signs with a mark or stamp, or another person helps.

State-Approved Signatures

Reason the client did not sign this form (check box that applies):

Client has the following physical limitations _____

Client is unable to give informed consent because _____

The signer is (check box that applies):

Person designated in a written advance directive or power of attorney for health care

Court-appointed guardian with authority to make health care decisions

Other individual recognized by state law (spouse, parent, other family member, agency worker)

State-approved signature: _____ Date: _____

Relationship _____ Phone _____

Attach copy of advance directive, power of attorney for health care, or guardianship papers if available.

Signature By Mark

If the client signs with a mark, signatures of two witnesses are required:

Witness

Date

Witness

Date

Assistance with Form

If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signed

Date

Relationship to Beneficiary: _____