## Application for Enrollment into the Health and Drug Medicare-Medicaid Plan (MMP): Neighborhood INTEGRITY

To join **Neighborhood INTEGRITY**, you must have Rhode Island Medicaid, Medicare Part A, Medicare Part B, and be eligible for Medicare Part D. To apply for **Neighborhood INTEGRITY**, please call 1-844-602-3469 (TTY 711), or complete this application and mail it in the enclosed envelope.

| **Section 1 – All fields in this section are required (unless marked optional)** | | |
|---|---|---|
| Name (First, Middle Initial, Last): | | |
| Birth date (MM/DD/YYYY): | Sex:<br>☐ Female ☐ Male | |
| Phone number: (  ) | Another phone number: (  ) | |
| Address where you live (include apt/unit number): | | |
| City: | State: | Zip Code: |
| Address where you get your mail (if different from where you live): | | |
| City: | State: | Zip Code: |
| Emergency contact name (optional): | Emergency contact phone (optional):<br>(  ) | |
| **Answer these important insurance questions:** | | |
| Some people have other health insurance and/or drug coverage through other insurance providers, such as private insurance, TRICARE, Employers, Unions, Railroad Retirement, Veterans Affairs, or RIPAE (RI Pharmaceutical Assistance to the Elderly) Program.<br><br>If you have health and/or drug coverage from an Employer, Union or Railroad Retirement Board now, you or your dependents could lose that coverage when you join Neighborhood INTEGRITY. Your Employer, Union or Railroad Retirement Plan can give you more information about your coverage. | | |

Applicant Name:_____

| | |
|---|---|
| Do you have other health coverage? ☐ Yes ☐ No<br>If answered "yes", fill in the information below: | |
| Name of your plan *(and employer, if applicable)*: | Group number:<br>ID number: |
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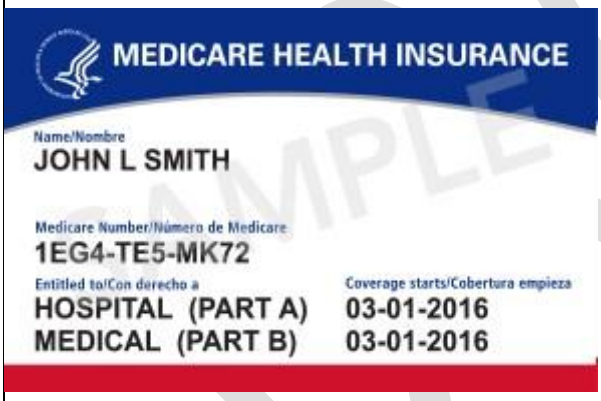
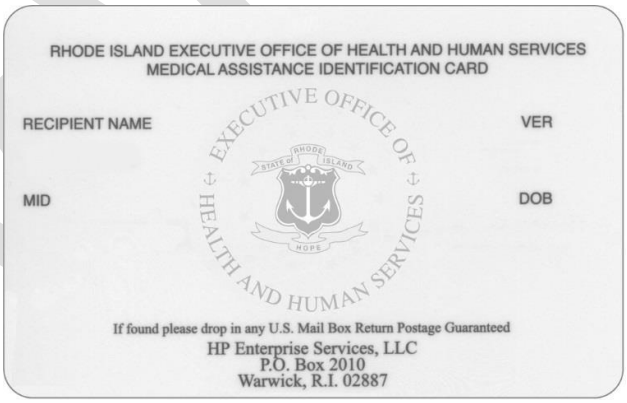
**Your Medicare and Rhode Island Medicaid Coverage:**

Write your Medicare and Medicaid ID number on the line below for each card.




**Medicare ID:** _____

**Rhode Island Medicaid ID:** _____

**Other personal information:**

Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If answered "yes" and you have had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your health care provider.

Do you live in a long-term care facility (such as a nursing home)? ☐ Yes ☐ No

If answered "yes", fill in the information below:

Name of facility: _____ Phone number: _____

## Section 3 – All fields in this section are optional

**Answering these questions is <u>your choice</u>.**

**You cannot be denied coverage if you do not fill them out.**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

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

What is your race? Select all that apply.

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

Select one if you want us to send your information in a language other than English.

☐ Portuguese
☐ Spanish
☐ Other (write language below) _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Neighborhood INTEGRITY at 1-844-812-6896 (TTY 711) if you need information in an accessible format other than what is listed above. Their Member Services hours are Monday – Friday, 8:00 am to 8:00 pm, and Saturday, 8:00 am to 12:00 pm.

Are you married? ☐ Yes ☐ No

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Do you have an e-mail address? If yes, enter it below.

E-mail address: _____

Who is your current Primary Care Provider (PCP), clinic, or health center?

Name of PCP, clinic, health center: Phone number:

_____ _____

## Section 4 – Please read and sign below

When you sign this form, it means that you understand:

- Neighborhood Health Plan of Rhode Island ("Neighborhood INTEGRITY") has a contract with the federal government and with the state of Rhode Island.
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The health services you get with your new plan may be different than the services you had before.
- You must keep Hospital (Medicare Part A), Medical (Medicare Part B) and continue to be eligible for Rhode Island Medicaid to stay enrolled in Neighborhood INTEGRITY.
- People with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- You can be in only one Medicare plan at a time.
- By joining Neighborhood INTEGRITY, you will end your enrollment in another Medicare Advantage and/or prescription drug plan.
- You must tell Medicare and the Rhode Island Medicaid program about any prescription drug coverage that you have or may get in the future.
- If you move, you need to tell Rhode Island Medicaid your new address.
- As a member of Neighborhood INTEGRITY, you have the right to appeal if you do not agree with Neighborhood's decisions about payment or services.
- On the date Neighborhood INTEGRITY coverage begins, you must get my health care from providers in Neighborhood's network, except for emergency or urgently needed care, out-of-area dialysis, or if you get Neighborhood's approval to see other providers in some circumstances.
- When Neighborhood INTEGRITY coverage begins, you must get all of my medical and prescription drug benefits from Neighborhood INTEGRITY. Benefits and service provided by Neighborhood INTEGRITY and included in my Neighborhood INTEGRITY "Evidence of Coverage" document (also known as the Member

Handbook) will be covered. Neither Medicare nor Neighborhood INTEGRITY will pay for benefits or services that are not covered.

- If you need to see a doctor or other provider who is not in Neighborhood INTEGRITY, you may need prior authorization (permission before you get the service) or you may have to pay out-of- pocket for the services you get.
- By joining Neighborhood INTEGRITY, you know that Neighborhood may share your information with Medicare and the Rhode Island Medicaid program and other plans as necessary for treatment, payment, and health care operations.
- You understand that prescription drugs are covered but not always the same ones you are already taking. You understand that you will be able to receive at least one 30-day supply of prescription drugs anytime during the first 90 days of coverage in Neighborhood INTEGRITY.
- You understand that when you join Neighborhood INTEGRITY, you need to use Neighborhood's network of doctors and other providers. However, you will have access to continue to see your current doctors for the first 180 days of coverage in Neighborhood INTEGRITY. After that time, if you want to see doctors or other providers who are not in Neighborhood's network, you will have to get permission to see them from Neighborhood INTEGRITY first.
- You know that Neighborhood Health Plan of Rhode Island will share my information including my prescription drug information with Medicare and the Rhode Island Medicaid program, who may use it to track your enrollment, make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

**Signatures**

The information on this application 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 Neighborhood INTEGITY.

My signature and/or my authorized representative's signature (the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application.

**Applicant Signature:** **Date:**

_____ _____

If signed by an authorized representative, their signature certifies that:

1.) This person is authorized under State law to complete this enrollment application, and
2.) Documentation of this authority is available upon request by Medicare and/or Rhode Island Medicaid

Name (please print): _____

Signature: _____

Applicant Name:_____

Address: _____
Phone number: _____
Relationship to applicant: _____
Today's date:_____

**If you have questions about Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov. TTY users should call 1-877-486-2048.

**If you are mailing the application, please send to:**

Medicare-Medicaid Plan Enrollment Line

401 Wampanoag Trail, 3rd floor

East Providence, RI 02915

An envelope is enclosed for your use. **You can also call 1-844-602-3469 (TTY 711) to apply**.

**For more information**, visit www.eohhs.ri.gov.

**If you have questions**, call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday- Friday, 8:00 am – 6:00 pm. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

**Para obtener más información**, visite www.eohhs.ri.gov. Si tiene preguntas, llame al Medicare-Medicaid Plan Enrollment Line (número telefónico para inscripciones en plan Medicare-Medicaid) al 1-844-602-3469 (TTY 711), de lunes a viernes, de 8:00 a.m. a 6:00 p.m. La llamada es gratis. Puede obtener esta información gratuitamente en otros idiomas y formatos, como letra grande, braille y audio.

**Para mais informações**, visite www.eohhs.ri.gov. Se tiver dúvidas, ligue para a Linha de Inscrição do Plano de Medicare-Medicaid no número 1-844-602-3469 (TTY 711), de segunda a sexta-feira, das 8:00 às 18:00. A chamada é gratuita. Você pode obter estas informações gratuitamente em outros idiomas e formatos, como impressão grande, braile e áudio.

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan