

2020 Providence Medicare Advantage Plan Information

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

[Star Rating](#)

Download Application: [Prime, Bridge 1, Choice 1, Extra](#) / [Focus & Select](#) / [Timber, Bridge 2, Choice 2, Extra 2](#) / [Compass & Latitude](#) / [Enrich](#)

Summary of Benefits: [Bridge 1](#) / [Bridge 2](#) / [Choice](#) / [Compass](#) / [Enrich](#) / [Extra](#) / [Focus](#) / [Prime](#) / [Select](#) / [Timber](#) / [Latitude](#)

[Pharmacy & Provider Search](#)

[Formulary](#)

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: [Click here](#)
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: <https://medicare-oregon.com/>

Y0062_MULTIPLAN_CDA INSURANCE Oregon 2020

2020 Providence Medicare Advantage Plans Enrollment Request Form

Please contact Providence Medicare Advantage Plans if you need information in another language or format.

Plan Selection

Columbia, Lane, Marion and Polk counties in Oregon and Clark County in Washington:

- | | |
|---|---|
| <input type="checkbox"/> Timber + Rx (HMO): \$0.00 | <input type="checkbox"/> Bridge 2 + Rx (HMO): \$40.00 |
| <input type="checkbox"/> Choice + Rx 002 (HMO-POS): \$88.00 | <input type="checkbox"/> Extra + Rx 002 (HMO): \$173.00 |

(Optional) Dental Plan Selection**

Extra, Timber and Bridge plans only:

- | |
|---|
| <input type="checkbox"/> Basic Wrap: \$29.40 will be added to your medical premium. |
| <input type="checkbox"/> Enhanced Wrap: \$42.20 will be added to your medical premium. |

Choice plan only:

- | |
|--|
| <input type="checkbox"/> Basic: \$33.70 will be added to your medical premium. |
| <input type="checkbox"/> Enhanced: \$46.50 will be added to your medical premium. |

Your Information

Mr. Mrs. Ms. _____
LAST NAME FIRST NAME MI

_____/_____/_____
BIRTHDATE (MMDDYYYY) EMAIL ADDRESS PHONE NUMBER

SEX: Male Female _____
PERMANENT RESIDENCE STREET ADDRESS (P.O. BOX IS NOT ALLOWED)

CITY COUNTY STATE ZIP CODE

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT RESIDENCE ADDRESS)

CITY COUNTY STATE ZIP CODE

EMERGENCY CONTACT RELATIONSHIP TO YOU PHONE NUMBER

**I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional plan selected. Additionally, I understand that I must pay the optional plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

Medicare Insurance Information

Please fill in the blank information fields below so that they match what appears on your red, white and blue Medicare card.

MEDICARE HEALTH INSURANCE

NAME _____

MEDICARE NUMBER _____

ENTITLED TO: COVERAGE STARTS:

HOSPITAL (PART A) _____/_____/_____

MEDICAL (PART B) _____/_____/_____

Or: You can attach a copy of your Medicare Card or your letter from Social Security or Railroad Retirement Board.

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

OFFICE USE ONLY AEP ICEP/IEP SEP (Type): _____ Not Eligible: _____

AGENT/PRODUCER NAME (IF ASSISTING) _____ DATE _____/_____/_____ EFFECTIVE COVERAGE DATE _____/_____/_____ PLAN # _____

PBP _____ TRAN. CODE _____ PREMIUMS _____ GROUP # _____ CONTRACT # _____

Attestation of Eligibility

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from Oct. 15th through Dec. 7th 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 and check at least one that 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 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 am leaving employer or union coverage 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 belong to a pharmacy assistance program provided by my state.
- I am enrolling during the Annual Enrollment Period or Special Enrollment Period.
- I recently left a PACE program on (insert date): ____/____/____
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- 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 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 am moving into, live in, or recently moved out of a Long-Term Care Facility. I moved/will move into the facility on (insert date): ____/____/____ I moved/will move out of the facility on (insert date): ____/____/____
- I was recently released from incarceration 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 recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ____/____/____
- My plan is ending its contract with Medicare or Medicare is ending its contract with my plan (insert date): ____/____/____
- I recently obtained lawful presence status in the United States. I got the status on (insert date): ____/____/____

Attestation of Eligibility (continued)

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 have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): ___ ___/___ ___/___ ___

I was impacted by a significant network change with my current plan and was notified 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 statements here applied to me, but I was unable to make the enrollment because of the natural disaster.

Other qualifying event(s) (please list): _____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY: 711) to see if you are eligible to enroll. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

Important Questions

<p>1. Do you have End-Stage Renal Disease (ESRD)? If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis. If we don't receive a note or records from your doctor we may need to contact you to obtain additional information.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Do you or your spouse work?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Will you have additional coverage apart from a Providence Medicare Advantage Plan? Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs. Please list your other coverage and your identification (ID) number for this coverage:</p> <p>NAME OF OTHER COVERAGE _____</p> <p>ID # FOR THIS COVERAGE _____ GROUP # FOR THIS COVERAGE _____</p> <p>CHECK ALL THAT APPLY:</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Prescription</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Are you a resident in a long-term care facility, such as a nursing home? If "yes", please provide the following information:</p> <p>NAME OF INSTITUTION _____ PHONE NUMBER OF INSTITUTION _____</p> <p>ADDRESS OF INSTITUTION _____</p> <p>CITY _____ STATE _____ ZIP _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Are you enrolled in a State Medicaid program? If "yes", please provide your Medicaid number: _____</p> <p>MEDICAID NUMBER</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Please choose the name of a Primary Care Provider (PCP):</p> <p>FIRST & LAST NAME OF PCP _____ CLINIC NAME/PCP LOCATION _____</p>	

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY: 711) if you need information in an accessible format or language other than English. Our office hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

Payment Method

Please select one of the options below. If you don't select a payment option, you will receive a bill each month.

Receive a monthly bill

Once you receive your first bill, you can choose a different payment option:

- + You can pay by credit, debit card, checking, or savings account: One-time or recurring payments can be made via your myProvidence account found at myprovidence.healthtrioconnect.com or through our Providence website at providence.org/billpay.
- + You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 1-888-821-2097 (TTY users call 711).

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/RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bills for your monthly premiums.)

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

If you are assessed a Part D-IRMAA, 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 RRB. DO NOT pay Providence Medicare Advantage Plans the Part D-IRMAA.

Extra Help for Limited Incomes

People with limited incomes may qualify for Extra Help to pay 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 co-insurance. 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 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.

Late Enrollment Penalty

Some members are required to pay a Part D late enrollment penalty because they did not join a Medicare drug plan when they initially became eligible or because they went a continuous period of 63 days or more without "creditable" prescription drug coverage. ("Creditable" means the drug coverage is generally expected to pay at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

STOP – Important Information

If you currently have health coverage from an employer or union, joining Providence Medicare Advantage Plans could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Providence Medicare Advantage Plans. 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 benefit administrator or the office that answers questions about coverage can help.

Read and Sign Below

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

Providence Medicare Advantage Plans 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 maybe get in the future. I understand that if I don't have Medicare prescription drug coverage, or a creditable prescription drug coverage plan (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, when an enrollment period is available (Example: October 15th–December 7th of every year), or under certain special circumstances.

Providence Medicare Advantage Plans serves a specific service area. If I move out of the area that Providence Medicare Advantage Plans 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 Providence Medicare Advantage Plans, I have the right to appeal plan decisions about payment or service if I disagree.

I will read the Evidence of Coverage from Providence Medicare Advantage Plans 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 selecting a Providence Medicare (HMO) plan means that on the date coverage begins, I must get all of my health care from Providence Medicare Advantage Network Providers, except for emergency or urgently needed services or out-of-area dialysis services. I understand that selecting a Providence Medicare (HMO-POS) plan means that with some exceptions, I may get non-urgent or non-emergent health care from providers outside the Providence Medicare Advantage Network at a higher cost-sharing should I choose.

Services authorized by Providence Medicare Advantage Plans and other services contained in my Providence Medicare Advantage Plans Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered provided plan rules are followed. If plan rules are not followed, **NEITHER MEDICARE NOR PROVIDENCE MEDICARE ADVANTAGE PLANS 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 Providence Medicare Advantage Plans, he/she may be paid based on my enrollment in Providence Medicare Advantage Plans.

Authorization & Declaration

Release of Information: By joining this Medicare health plan, I acknowledge that Providence Medicare Advantage Plans will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Providence Medicare Advantage Plans will release my information including my prescription drug event data if I am on a prescription drug plan 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.

Applicant signature

SIGNATURE ____/____/____
TODAY'S DATE

If the applicant is unable to sign the application and you are the authorized representative, please sign above and provide the requested information below:

NAME

ADDRESS

CITY **COUNTY** **STATE** **ZIP CODE**

RELATIONSHIP TO ENROLLEE **PHONE NUMBER**

Submission Options

Mail pages to: Providence Medicare Advantage Plans P.O. Box 5548 Portland, OR 97228-5548	Scan and fax pages to: 503-574-8653	Scan and email pages to: provMedicare@providence.org
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 **AGENT USE ONLY**

AGENT NAME _____
DATE

NPN # _____
REQUESTED DATE OF COVERAGE