blue california

Blue Shield of California Medicare Advantage Change of Plan Form

Current Blue Shield of California Medicare Advantage Plan members may use this short enrollment form to enroll into a Medicare Advantage Plan offered by Blue Shield of California.

Please fax or mail your completed enrollment form to:
Fax: (877) 251-3660
Mail: Blue Shield of California, PO Box 948, Woodland Hills, CA 91365-9856

I am currently a member of the _____ plan in _____ with a monthly premium of $ _____.

Select the plan you want to join:

Blue Shield TotalDual Plan (HMO D-SNP)
☐ Los Angeles/San Diego Counties ($0 per month)

I understand that this plan has different health benefits and may have a monthly premium, as stated above.

Member Number:

Last Name:	**First Name:**	**Middle Initial (optional):**
Phone Number :	**Phone Type:** ☐ Landline ☐ Mobile	

Permanent Street Address: (Don't enter a P.O. Box)

Street Address

City | State | ZIP Code

Mailing Address, if different from your permanent address (P.O. Box allowed):

Street Address

City | State | ZIP Code

Name of chosen Primary Care Physician (PCP) or clinic (HMO only):

Answering these questions is your choice. You can't be denied coverage because you don't 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
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

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

- ☐ Arabic
- ☐ Armenian
- ☐ Cambodian
- ☐ Chinese (Simplified)
- ☐ Chinese (Traditional)
- ☐ Farsi
- ☐ Korean
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

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

- ☐ Braille
- ☐ Large Print
- ☐ Audio CD

Please contact D-SNP Customer Service at **(800) 452-4413 (TTY: 711)** if you need information in an accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week.

Mobile Phone Number:

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or you may choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call D-SNP Customer Service at **(800) 452-4413 (TTY: 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/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 Railroad Retirement Board.
Do NOT pay Blue Shield of California the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, 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 won't have a coverage gap or a late enrollment penalty. Many people qualify 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 **(800) 772-1213**. TTY users should call **(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.

Please Read and Sign Below

Blue Shield of California is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield of California, he/she may be paid based on my enrollment in Blue Shield of California.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Blue Shield of California 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 people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my Blue Shield Medicare Advantage HMO Plan coverage begins, I must get all of my health care from Blue Shield of California, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Blue Shield of California and other services contained in my Blue Shield of California *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD OF CALIFORNIA WILL PAY FOR THE SERVICES**.

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 (MM/DD/YYYY):**

If you are the authorized representative, you must sign the previous page and provide the following information:

Name:

Address:

City State ZIP Code

Phone Number:

Relationship to Enrollee:

Producer information: Producer name and ID or NPN **is required**.

Agency name: _____
(please print appointed agency name)

Agency ID #: _____
(please print agency tax ID)

Producer (writing agent) name (required): _____
(please print writing agent name)

Producer ID #: _____
(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): _____
(please print NPN or TIN number)

Producer phone number: _____

Producer email address: _____

Date application received by producer (MM/DD/YYYY): _____

Producer signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.