INTEGRA
Managed Care
1981 Marcus Ave., Ste 100, Lake Success, NY 11042 Att: Medicare Division● 1 (877)-388-5190, TTY: 711

Please contact Integra Managed Care if you need information in another language or format (Braille)

To Enroll in Integra Managed Care, Please Provide the Following Information:

Please check which plan you want to enroll in:

_____ Harmony (HMO SNP) **$0 per month**

_____ Synergy (HMO SNP) **$0 per month**

LAST Name:	FIRST Name:	Middle Initial	☐Mr ☐Mrs. ☐Ms.

Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Home Phone Number: ( ) (Optional) Alternative Phone Number: ( )

Permanent Residence Street Address: (P.O. Box is not allowed)

City:	(optional) County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

(Optional field) Emergency contact: _____

Phone Number: (____)_____ **Relationship to You _____**

(Optional field) E-mail Address: _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

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

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Paying Your Plan Premium

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 RRB. DO NOT pay Integra Managed Care the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for 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 www.socialsecurity.gov/prescriptionhelp.

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? □ Yes □ No

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, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Integra Managed Care? □ Yes □ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	Eff Date:	ID # for this coverage:	Group # for this coverage
_____	_____	_____	_____

3. Are you a resident in a long-term care facility, such as a nursing home? □ Yes □ No

If "yes" please provide the following information:

Name of Institution:

_____

Address & Phone Number of Institution (number and street):

_____

4. Are you enrolled in your State Medicaid program? □ Yes □ No

If yes, please provide your Medicaid number:

_____

5. Do you or your spouse work? □ Yes □ No

6. Have you been determined eligible for a nursing home level of care? □ Yes □ No

(Optional field) Please Choose a Primary Care Physician (PCP):

Name:_____

Provider ID#:_____ **Provider Phone #** _____

Address:_____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

Spanish _____ Large Print _____ Braille _____

Please contact Integra Managed Care at 1.877-388-5195 if you need information in another format or language than what is listed above. Our office hours are Sunday to Saturday 8am to 8pm. After March 31, 2019, Member Service will be operated by alternate technology. TTY users call 711.

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Integra Managed Care could affect your employer or union health benefits. You could lose your employer or union heath coverage if you join Integra Managed Care HMO. 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 is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

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

Integra Managed Care is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my 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 may get 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 15 – December 07 of every year), or under certain special circumstances.

Integra Health serves a specific service area. If I move out of the area that Integra Managed Care 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 Integra Managed Care, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Integra Managed Care 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 beginning on the date Integra Managed Care coverage begins, I must get all of my health care from Integra Managed Care, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Integra Managed Care and other services contained in my Integra Managed

Care Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR INTEGRA MANAGED CARE 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 Integra Managed Care, he/she may be paid based on my enrollment in Integra Managed Care.

Release of Information: By joining this Medicare health plan, I acknowledge that Integra Managed Care HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Integra Managed Care 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 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:**

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

Name : _____

Address: _____

Phone Number: (_____) _____- _____

Relationship to Enrollee _____

Office Use Only:

Name of staff member /agent /broker (if assisted in enrollment):_____

Plan ID #: 001_____ 002____ 005____ 006____ Effective Date of Coverage:_____

Enrollment Type: Integra Managed Care Agent_____ Online_____ Medicare .Gov____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____