SeniorWholeHealth

Enrollment Application Forms

Medicare Advantage Enrollment Form

Name (Last, First, Middle Initial)
Mr.
Ms.
Mrs.
Date of Birth
Gender
Male
Female
Social Security #
Phone (Home)
Phone (Cell)
Permanent Residence Street Address
Apartment #
City
State
Zip
Mailing Address (Only if different from Residency)
Apartment #
City
State
Zip
Emergency Contact (Optional)
E-mail Address (Optional)
Contact's Relationship
Contact's Phone Number
Primary Spoken Language
Primary Written Language

Please take out your Medicare Card to complete this selection.

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.

You must have Medicare ***Part A*** and ***Part B*** to join a Medicare Advantage Plan

SAMPLE ONLY

Name

Gender: Male Female

Medicare Claim Number

Is Entitled To Effective Date Hospital (Part A)

Medical (Part B)

Name
Type of Medicaid
Medicaid ID Number

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. Do you have other prescription drug coverage?

Yes

No

If “Yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:

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 (Number and Street)

4. Do you or your spouse work? Yes No

Please choose the name of a Primary care Physician (PCP), clinic or health center (if required):

Your Signature
Date
If you are the authorized representative, you must provide the following information: Name:

Address:
Phone Number:
Relationship to Enrollee
Name of Staff Member (If assisted in enrollment):
Plan ID #:
Effective Date of Coverage:

Medicaid Advantage and Medicaid Advantage Plus Enrollment Form

Date of Birth
Gender
Male
Female
Case Number
Client Identification # (CIN) (NYS Benefit Card)
Social Security #
HIC Number (Medicare)
Address
Apartment #
City
State
Zip
County
Phone (Cell)
Phone (Home)
Phone (Other)
Primary Care Provider

Primary Language
English
Spanish
Russian
Chinese
Haitian Creole
Other

The information that I have given in my application is true to the best of my knowledge. I understand enrollment in Medicaid Advantage or Medicaid Advantage Plus is voluntary. I have been told the rights and benefits that I will have as a member of Medicaid Advantage or Medicaid Advantage Plus and the conditions of participation. I know that I must be enrolled in the same health plan's Medicare Advantage product to enroll or stay enrolled in Medicaid Advantage or Medicaid Advantage Plus.

I CONSENT TO THE RELEASE OF ANY MEDICAL INFORMATION ABOUT ME:

By my primary care provider (PCP), by any other health care provider, or by the New York State Department of Health (SDOH) to SENIOR WHOLE HEALTH and any health care providers involved in caring for me as reasonably necessary for SENIOR WHOLE HEALTH or my providers to carry out treatment, payment, or health care operations.

This may include pharmacy and other medical claims information needed to help manage my care.

By SENIOR WHOLE HEALTH and any health care providers to SDOH and other authorized federal, state and local agencies for purpose of administration of the Medicare and Medicaid programs, and

By SENIOR WHOLE HEALTH to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations

I also agree that HIV/AIDS,mental health, or alcohol substance abuse information about me may be released, to the extent permitted by law, for as long as I remain enrolled in SENIOR WHOLE HEALTH. I know that

I can revoke this consent at any time by notifying SENIOR WHOLE HEALTH in writing, except that this would not apply to information that has already been released.

I understand that other federal, state, and local laws may protect the confidentiality of my personal health information.

I wish to enroll in SENIOR WHOLE HEALTH Medicaid Advantage and understand that enrollment is voluntary.

If at the time of my enrollment, it is determined that I am eligible for long-term care services per New York State Department of Health rules and regulations, I agree to enroll in SENIOR WHOLE HEALTH Medicaid Advantage Plus, and I understand my enrollment in SENIOR WHOLE HEALTH Medicaid Advantage Plus is voluntary.

I will choose to stay in SENIOR WHOLE HEALTH Medicaid Advantage and obtain my long-term care services from regular Medicaid. I understand that I can change my mind should I want to enroll in SENIOR WHOLE HEALTH Medicaid Advantage Plus.

If, during the course of enrollment in SENIOR WHOLE HEALTH Medicaid Advantage, I become eligible for SENIOR WHOLE HEALTH Medicaid Advantage Plus,

I agree to enroll in SENIOR WHOLE HEALTH Medicaid Advantage Plus, and I understand my enrollment in SENIOR WHOLE HEALTH Medicaid Advantage Plus is voluntary.

I will choose to stay in SENIOR WHOLE HEALTH Medicaid Advantage and obtain my long-term care services from regular Medicaid. I understand I can change my mind should I want to enroll in SENIOR WHOLE HEALTH Medicaid Advantage Plus.

I have received and have had the Member Handbook(s) explained to me which includes the rules and responsibilities of plan membership and a description of covered and non-covered.

I agree to participate in SENIOR WHOLE HEALTH according to the terms and conditions described in the Member Handbook(s).

As a participant, I agree to receive all covered service from *SENIOR WHOLE HEALTH'S* network of providers.

Further, I understand that I must choose my PCP and any specialty physician from *SENIOR WHOLE HEALTH'S* list of network providers. I have been given a copy of the provider network list. I understand that my anticipated date of enrollment is [blank].

I understand that my Enrollment Application must be approved by the local county department
of social services.

I understand that as a participant, I agree to allow all my service providers and the health information (PHI) with family members or other persons who are involved in my treatment plan or payment of my services, as designated below:

I understand that as a participant, I agree to allow all my service providers and the Senior Whole Health staff to share information and communicate regarding my medical conditions and treatment plans.

I understand that Senior Whole Health staff may at times share my personal health information (PHI) with family members or other persons who are involved in my treatment plan or payment of my services, as designated below:

Name of Designee Relationship Phone
Name of Designee Relationship Phone
Name of Designee Relationship Phone
Signature of Participant
Date
Print Name of Family Member or Guardian (if applicable)
Signature of Family Member or Guardian (if applicable)
Date
Print Witness's Name
Signature of Witness
Date
Print Intake Specialist's Name
Signature of Intake Specialist
Date

Authorized Plan Representative Use Only
SWH Certification: Medicare Advantage Application complete for CMS Submission: Date