MedCare Partners
Health Plan of Texas

OMB No. 0938-1378
Expires: 2/28/2029

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
MedCare Partners Health Plan
21216 Northwest Freeway, Suite 260
Cypress, TX 77429

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call MedCare Partners Health Plan at 1-888-980-3040. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a MedCare Partners Health Plan al 1-888-980-3040 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ MedCare Classic (HMO) PBP 001 – $0 per month

☐ MedCare Focus (HMO C-SNP) PBP 002 – $0 per month

☐ MedCare Choice (HMO C-SNP) PBP 003 (Chronic & LIPSA) - $6.00 per month

FIRST name:	LAST name:	Middle Initial (Optional):

Birth date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: _ _ _ _ _ _ _ _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to MedCare Partners Health Plan?
☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:
_____	_____	_____

Special Needs Plan Eligibility

Enrollment in some of the plans listed above requires that you have certain chronic conditions. Have you been diagnosed with any of the following chronic conditions (check all that apply):

☐ Diabetes
☐ Congestive Heart Failure (CHF)
☐ Cardiovascular Disorders, including any of these diagnoses:
  ☐ Cardiac arrhythmias
  ☐ Coronary artery disease
  ☐ Peripheral vascular disease or
  ☐ Chronic venous thromboembolic disorder

IMPORTANT: Read and sign below:	
• I must keep both Hospital (Part A) and Medical (Part B) to stay in MedCare Partners Health Plan. • By joining this Medicare Advantage, I acknowledge that MedCare Partners Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. • I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans). • I understand that when my MedCare Partners Health Plan coverage begins, I must get all of my medical and prescription drug benefits from MedCare Partners Health Plan. Benefits and services provided by MedCare Partners Health Plan and contained in my MedCare Partners Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor MedCare Partners Health Plan will pay for benefits or services that are not covered. • 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.	
Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

☐ Spanish ☐ Vietnamese ☐ Other: _____

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact MedCare Partners Health Plan at 1-888-980-3040 if you need information in an accessible format other than what's listed above. Our office hours are 8:00am to 8:00pm local time, 7 days a week from October 1 through March 31 and 8:00am to 8:00pm, Monday through Friday from April 1 through September 30. TTY users can call 711.

Section 2 – All fields in this section are optional

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

List your Primary Care Physician (PCP): _____

Address: _____ Phone: _____ Fax/Email: _____

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Provider/Pharmacy Directory ☐ Formulary (Drug List) ☐ Member Newsletter

E-mail address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, "Electronic Funds Transfer (EFT)", or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay MedCare Partners Health Plan the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Effective Date of Coverage: _____ Agent Submission Date to Plan: _____

Enrollment Period: ☐ AEP ☐ ICEP ☐ SEP type: _____ ☐ MA OEP

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.