220 Alexander St.
Rochester, NY 14607
www.mvphealthcare.com

MVP MEDICARE HMO PLAN CHANGE FORM
Buffalo, Central, East and Rochester Regions

Section 1: Member Information			
Last Name	First Name	Mid. Init.	Telephone Number ( )
MVP Member ID #		Date of Birth / /	

Section 2: Reason(s) for Change

Please read the following statements carefully and check the box if the statement applies to you. We may contact you for more information.

- ☐ I am new to Medicare (turning 65 or due to disability).
- ☐ 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: ____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on:____.
- ☐ I am moving into, live in, or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility). Move date: ____.
- ☐ I recently left a PACE program on: ____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's) on____.
- ☐ I am leaving employer or union coverage on: ____.
- ☐ I belong to a pharmacy assistance program provided by my state (EPIC).
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: ____.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ None of the statements applies to me. Please call us to see if you are eligible to enroll: **1-888-280-6205 or TTY: 1-800-662-1220.**

Section 3: Change Your Medical Plan or Drug Coverage

I want to change my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month. (Select one)

☐ GoldValue HMO **with** MVP Part D

☐ Preferred Gold HMO **without** MVP Part D

☐ Preferred Gold HMO **with** MVP Part D

Section 4: Primary Care Physician (PCP)

Primary Care Physician (full name required): ____

Are you an existing patient? ☐ Yes ☐ No

Please Sign on Back

Section 5: Your Plan Premium

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 coinsurance. 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.**

Note: If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay part of your plan premium. We will bill you for the amount that Medicare does not cover.

Please select how you would like to pay your premium:

☐ Please bill me.

☐ Automatic deduction from my monthly SSA benefit check. (The first deduction may take several months to begin. It will include all premiums due.

If you do not select Medicare prescription drug coverage and do not have creditable coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

If you don't select a payment option, MVP will bill you monthly.

Please contact MVP if you need information in another language or format (Braille).

Section 6: Signature and Authorization

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where I live) on this application means that I have read and understand the contents of this change form. If signed by an authorized individual (as described above) this signature certifies that:

- This person is authorized under State law to complete this enrollment, and
- Documentation of this authority is available upon request by MVP or Medicare.

If you are selecting Medicare prescription drug coverage and have not had creditable coverage, you may have to pay a late enrollment penalty. The penalty amount will be added to your monthly premium.

Signature ____ **Date** ________________

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

Name ____________________________ Address ________________________________

Phone Number ______________________ Relationship to Enrollee ______________________

For Plan Use Only

Enter in: ☐ Amisys ☐ Facets		Member ID number: A ____________ or 8 ____________		
Group Name	Group #	Effective Date Requested	Input Date	Initials

ICEP/IEP ☐ AEP ☐ SEP ☐ (type):

Date coverage should begin: / /

For more information, go to **www.mvphealthcare.com**