

**Pre-Qualification Assessment for
Fresenius Health Partners (PPO SNP).**



Fresenius

Please Complete the Following Information:

Name:		Date of Birth:	
Address:			
City:		State:	Zip:
Is this a licensed nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Medicare

Do you have Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Medicare Claim Number: _ _ _ - _ _ - _ _ _ _ _
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
If the answer is "No" to either question, the beneficiary does not qualify.	

Medical History

Do you have renal disease and are currently on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no" candidate does not qualify.	
Name of diagnosing physician and his/her clinic:	Phone:
Address:	

Applicant Attestation

Candidate Signature:		Date:
<i>If you are the enrollee's legal authorized representative, you must provide the following information:</i>		
Name (Print):	Relationship to Enrollee:	
Signature:	Date:	
Agent/Broker (Please Circle One)	Agent/Broker Name (Print):	
Agent/Broker Signature:	Date:	

Authorization for Release of Medical Information

Name:	
Maiden/Other Names Known by:	Date of Birth:
I authorize release of my medical records to Fresenius Health Partners by any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf. Release Records to: Attn: SNP Enrollment, Fresenius Health Partners 7100 Commerce Way, Suite 285, Brentwood, TN 37027	
Signature of Patient / Legal Representative:	
Relationship to Patient:	Date:



Fresenius Health Partners
PPO SNP
 Accountable Kidney Care



Fresenius

Underwritten by Sterling Life Insurance Company

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- 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 (insert date) _____.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- 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 (insert date) _____.
- 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). I moved/will move into/out of the facility on (insert date) _____.
- I recently left a PACE program on (insert date) _____.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.
- I am leaving employer or union coverage on (insert date) _____.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact Fresenius Health Partners (PPO SNP) at 1-866-307-3625 (TTY users should call 1-877-736-2535) to see if you are eligible to enroll. We are open 8 a.m. - 8 p.m. in your local time zone, seven days a week.

Please contact Fresenius Health Partners if you need information in another language or format (Braille).

To Enroll in Fresenius Health Partners, Please Provide the Following Information:

Please check which plan you want to enroll in:

<input type="checkbox"/> Fresenius Health Partners (PPO SNP) GA	H9988-017	\$30.00 per month
<input type="checkbox"/> Fresenius Health Partners (PPO SNP) NC	H9988-018	\$32.00 per month
<input type="checkbox"/> Fresenius Health Partners (PPO SNP) TN	H9988-019	\$30.00 per month
<input type="checkbox"/> Fresenius Health Partners (PPO SNP) TX	H5162-019	\$30.00 per month

LAST Name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (MM/DD/YYYY) (____/____/____)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (____)____-____	Alternate Phone Number: (____)____-____
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Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: _____ ZIP Code: _____

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 Social Security or the Railroad Retirement Board.

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

	
MEDICARE HEALTH INSURANCE	
SAMPLE ONLY	
Name _____	
Medicare Claim Number _____	Sex _____
Is Entitled To _____	Effective Date _____
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, bank draft or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

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 RRB. **DO NOT pay Fresenius Health Partners 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.

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.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- Get a bill.
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

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 Fresenius Health Partners? 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 & 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

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

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 Audio Compact Disk Braille

Please contact Fresenius Health Partners at 1-866-307-3625 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. seven days a week. TTY users should call 1-877-736-2535.

Please Read This Important Information



If you currently have health coverage from an employer or union, joining Fresenius Health Partners could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Fresenius Health Partners. 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 isn't any 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: Fresenius Health Partners is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare 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 7 of every year), or under certain special circumstances.

Fresenius Health Partners serves a specific service area. If I move out of the area that Fresenius Health Partners 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 Fresenius Health Partners, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fresenius Health Partners 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 Fresenius Health Partners coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Fresenius Health Partners provides refunds for all covered benefits, even if I get services out of network." Services authorized by Fresenius Health Partners and other services contained in my Fresenius Health Partners Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FRESENIUS HEALTH PARTNERS 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 Fresenius Health Partners, he/she may be paid based on my enrollment in Fresenius Health Partners.

Release of Information: By joining this Medicare health plan, I acknowledge that Fresenius Health Partners will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fresenius Health Partners 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: _____ Relationship to Enrollee: _____

Address: _____ Phone Number: _____

Office Use Only:

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

Plan ID#: _____ Effective Date of Coverage: _____

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

Seminar In-Home INV BD CC Agent ID#: _____

Agent Signature: _____ Date: _____