



Valley Baptist Health Plans

AN AFFILIATE OF VALLEY BAPTIST HEALTH SYSTEM

Valley Advantage GOLD, SILVER & SELECT

Important Instructions:

To become a member of Valley Baptist Health Plans, follow these easy steps!

Tell us about yourself. We need to know some things in order to make your enrollment effective.

- Last Name, First Name, Middle Initial
- Sex
- Birth date
- Home Address (*This should be your permanent residence street address*)
- Mailing Address (*If different from your home address*)
- Social Security Number
- County of Residence
- Emergency Contact Name and Phone Number
- Date you wish your Valley Baptist Health Plans coverage to begin

Tell us about your Medicare coverage. Fill in the section on your Medicare Insurance information. Fill in these blanks so that they match your red, white and blue Medicare card. You must have Medicare Part A and Part B to join Valley Baptist Health Plans.

Choose a Primary Care Provider and let us know if you are an established patient.

Select a Valley Advantage Benefit Plan. Valley Advantage Gold, Valley Advantage Silver and Valley Advantage Select all offer the Part D prescription drug coverage. Valley Advantage Select is only available to those with Medicare Part A and Part B and Medicaid. All plans available in the Cameron, Hidalgo, and Willacy County service area.

Answer the Yes / No question section. Your answers will not affect your eligibility to enroll in our plans. Valley Baptist Health Plans does not use health information for screening purposes.

Sign and date the application. If the applicant cannot sign, a person with Power of Attorney, or who is authorized by Texas State Law, must sign the Authorized Representative Signature line and provide contact information. Anyone helping the beneficiary fill out the application must sign the line for Individual Assisting Applicant and provide their relationship to the beneficiary.

If you have questions, please be sure to contact Member Services at (877) 422-4400 or TTY/TDD (800) 562-5259, Monday – Friday from 8:00 a.m. to 6:00 p.m.

Remember to tell us how you would like to make your payment for Valley Baptist Health Plans.

There are three payment options on the Premium Payment Option Form. You can make payment by:

1. Having your premiums for Valley Baptist Health Plans deducted from your monthly Social Security benefit check.
2. Sending your monthly check or money order to our office.
3. Automatic deduction from your checking account.

If you choose to have your payment deducted from your checking account (Option 3), please include a VOIDED personal check along with the completed Valley Baptist Health Plans Premium Payment Option Form.

Please remove this page before you complete the attached application.

Enrollment Application - Valley Advantage Gold, Silver & SELECT



Valley Baptist Health Plans
AN AFFILIATE OF VALLEY BAPTIST HEALTH SYSTEM

Office use Only

Plan ID#: _____
 Effective Date of Coverage: _____
 ICEP OEP AEP SEP
 VBHP Representative: _____

2005 Ed Carey Drive ■ Harlingen, Texas 78550
 (956) 389-2273 ■ Toll-Free (877) 422-4400

For the Hearing Impaired (TTY/TDD) (800) 562-5259
 Hours of Operation: Monday – Friday 8:00 a.m. – 6:00 p.m.

Last Name	First Name	M.I.	Sex	Birth Date
Home Address		Home Phone	Social Security Number	
City	State	Zip Code	County	
Mailing Address (if different)				
Emergency Contact Name		Phone		

PRIMARY CARE PROVIDER	Fill out this part as it appears on your Medicare card
Please refer to the Valley Baptist Health Plans Provider Directory for a complete list of participating physicians. Physician Name: _____ PCP ID#: _____ Established Patient?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name on your card: _____ Medicare Claim Number: _____ IS ENTITLED TO: _____ EFFECTIVE DATE: _____ Hospital Part A _____/_____/_____ Medical Part B _____/_____/_____

SELECT A BENEFIT PLAN: **GOLD** **SILVER** **SELECT**

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Yes No Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. **Note: If YES, see back of this form for important information.**

Yes No Have you recently moved into this plan's service area? If YES, on what date did you move?

Yes No Do you need special help understanding plan rules?
 Non-English Speaking Sight Impaired Hearing Impaired Reading Impaired

Yes No Are you a resident in an institution (e.g. skilled nursing facility, rehabilitation hospital)? If YES:
 Name of Institution _____ Phone Number of Institution _____/_____/_____
 Address (Street, City, Zip) _____ Your Date of Admission _____

Yes No Do you receive Medicaid benefits? If YES, Medicaid Number: _____

Yes No Do you, on your own or through your spouse, have any **health insurance** other than Medicare, such as private insurance, Workers' Compensation or VA Benefits? If YES, what kind of insurance do you have?
 Employer Plan Workers' Compensation VA Medicaid Other

Do you plan to keep this coverage after enrolling in Valley Baptist Health Plans? Yes No

Name of Insurance Company _____ Employer Name _____

Policy Holder Name _____ Policy Number _____

Yes No Do you have another prescription **drug coverage** in addition to Valley Baptist Health Plans? If YES, what kind of insurance do you have: TRICARE Federal Employee Benefits VA
 State Assistance Programs Other _____

I understand that my signature on this application means that I have read and understand the contents on the front and back of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this plan.

Applicant's Signature: _____ **Date:** _____

*If the individual cannot sign, a person with Power of Attorney, or who is authorized by Texas State law, must sign the following line. Attach a copy of proof of authorization by Texas State Law.

Authorized Representative Signature: _____ **Date:** _____

Name: _____ Relationship to Applicant: _____

Address: _____ Telephone: _____

If anyone helped the beneficiary fill out this form, that individual must sign the following line.

Individual Assisting Applicant Signature/Relationship to Beneficiary _____ Date _____

STOP

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Valley Baptist Health Plans could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Valley Baptist Health Plans may change how your current coverage works. Read the communications your employer or union sends you. If you have any 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.

I understand that if I join another Prescription Drug Plan (PDP), my membership in Valley Baptist Health Plans plan will automatically end. This means that Valley Baptist Health Plans will no longer be able to cover my doctor, hospital or pharmacy costs.

I understand that if I join the Select plan and I lose Medicaid coverage, my membership in Valley Baptist Health Plans will automatically end.

I understand that Valley Baptist Health Plans will send me final approval of my enrollment in the plan. I understand I should not disenroll from any Medicare supplement plan or Medigap/Medicare Select Plan until I get that approval from the plan. I understand that in most cases my enrollment will be the first day of the month after the month that Valley Baptist Health Plans receives a completed enrollment form.

Valley Advantage is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Valley Baptist Health Plans of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Valley Baptist Health Plans or by calling 1-800-MEDICARE. For the Hearing Impaired toll-free (TTY/TDD) users should call (877) 486-2048.

If you have end-stage renal disease (ESRD), you cannot enroll in this plan except under certain circumstances. If you have had a successful kidney transplant, please attach a note or records from your doctors showing you have had a kidney transplant and no longer need regular dialysis.

I understand that as a member of the plan, I have the right to complain about getting medical care or payment for care I have already received. I understand that I am required to tell the plan before I move to a new residence. I understand that if I move permanently out of the service area, Medicare requires the plan to disenroll me.

I understand that if my enrollment is accepted, I will receive a written Evidence of Coverage from Valley Baptist Health Plans that will describe my rights and responsibilities as a member of the Valley Advantage Plan.

I understand that, beginning on the date my Valley Advantage Plan coverage begins, I must get all of my health care from the Valley Baptist Health Plans provider network, with the exception of emergency or urgently needed services, or out-of-area dialysis services. I understand that services authorized by Valley Baptist Health Plans and other services contained in my Valley Baptist Health Plans Evidence of Coverage document will be covered. I also understand that without authorization, NEITHER MEDICARE NOR VALLEY BAPTIST HEALTH PLANS WILL PAY FOR THESE SERVICES. Coverage outside the United States is limited per Medicare guidelines.

I understand that by signing this application (*on front*), I am agreeing to follow all plan rules.

AUTHORIZATION AND DECLARATION

Release of Information: By joining this plan, I allow the Centers for Medicare and Medicaid Services (CMS) to give information to the plan. This information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS' agents the information needed for treatment, payment and other healthcare operations.

I certify that all the information contained on this application is true and complete to the best of my knowledge. Coverage may be terminated for misrepresentations on the application for enrollment, for fraudulent conduct by the Subscriber, for misuse of the Membership Care or for failure to comply with certain terms of the Valley Baptist Health Plans Evidence of Coverage.

Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this plan.

If you need this form in a different format (such as Spanish), please call us so that we can send you a copy.

Valley Baptist Health Plans, a DBA of Valley Baptist Insurance Company, a health plan with a Medicare contract.