2021
Providence Medicare Advantage Plans
Plan Change Form

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

Dear Providence Medicare Advantage Plans Member:

To make a change in the Medicare Advantage plan you have with Providence Medicare Advantage Plans, fill out the enclosed plan change form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us.

You can change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 – March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you select another plan and we receive your completed selection form by the end of any month, your new benefit plan will generally begin the first of the following month. Your monthly plan premium will be determined based on your plan selection as listed below. You may continue to see any Providence Medicare Advantage Plans primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2021 Summary of Benefits for the available options online.

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you.

Providence Medicare Advantage Plans

Plan Change Form

DATE ______ LAST NAME ______ FIRST NAME ______ MI ______ MEMBER NUMBER ______

I want to transfer from 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. If this form is received during October 15 through December 7, the effective date will generally be the 1st of January.

Please check the appropriate box below:

☐ Providence Medicare Dual Plus (HMO D-SNP)*

Monthly Premium Amount: $0

Out-of-Pocket Max:
+ In-Network: $3,400

Primary Care Provider visit:
+ In-Network: 0% of the cost for each visit

Specialist visit:
+ In-Network: 0% of the cost for each visit

Inpatient Hospital Coverage:
+ In-Network: $0 copay for each benefit period

Emergency Care: 0% of the cost

Ambulance:

0% of the cost

*Providence Medicare Dual Plus (HMO D-SNP) is available to you if you have Medicare Part A and B, you have full Oregon Health Plan (OHP) Medicaid benefits, and you live in Clackamas, Multnomah or Washington County. You must continue to pay your Medicare Part B premium. The Part B premium is covered for full dual enrollees who are eligible for Providence Medicare Dual Plus (HMO D-SNP). Premiums, co-pays, co-insurance and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

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 ______ DATE ___/___/___

PBP ______ TRAN. CODE ______ PREMIUMS ______ GROUP # ______ CONTRACT # ______

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY users should call 711) if you need information in an accessible format or language other than English. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

______________________________ ___ ___/___ ___/___ ___
SIGNATURE **TODAY'S DATE**

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

____
NAME

____
ADDRESS

____
CITY COUNTY STATE ZIP CODE

( ) -
PHONE NUMBER RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

AGENT USE ONLY

______________________________ ___ ___/___ ___/___ ___
AGENT NAME DATE

______________________________ ___ ___/___ ___/___ ___
NPN # REQUESTED DATE OF COVERAGE