

2023 Providence Medicare Advantage Plans Plan Change Form

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 attached 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 2023 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

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX) PHONE NUMBER

CITY COUNTY (OPTIONAL) STATE ZIP CODE

Mailing address, if different from your permanent address (PO Box allowed):

STREET ADDRESS

CITY STATE ZIP CODE

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	Primary Care Provider 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
Out-of-Pocket Max: + In-Network: \$8,300	Specialist visit: + In-Network: 0% of the cost for each visit		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 PLAN ID # EFFECTIVE DATE OF COVERAGE
(IF ASSISTED IN ENROLLMENT)

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

PBP TRAN. CODE PREMIUMS GROUP # CONTRACT #

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

- Braille
- Large print
- Audio CD

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 (OPTIONAL) STATE ZIP CODE

_____ _____
PHONE NUMBER RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:	Scan and fax pages to:	Scan and email pages to:
Providence Medicare Advantage Plans	503-574-8653	provMedicare@providence.org
P.O. Box 5548		
Portland, OR 97228-5548		

AGENT USE ONLY

_____	_____ / _____ / _____
AGENT NAME	DATE
_____	_____ / _____ / _____
NPN #	REQUESTED DATE OF COVERAGE

Attestation of Eligibility for an Enrollment Period

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 leaving employer or union coverage on (insert date): ____ ____/____ ____/____ ____

I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): ____ ____/____ ____/____ ____

I am enrolling during the Annual Enrollment Period (October 15-December 7).

I am enrolling during a Special Enrollment Period (insert special enrollment being used): _____

I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP)(January 1-March 31).

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 had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): ____ ____/____ ____/____ ____

I belong to a pharmacy assistance program provided by my state.

I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

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 the facility on (insert date): ____ ____/____ ____/____ ____
I moved/will move out of the facility 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 was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): ____ ____/____ ____/____ ____

I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State or local government entity.)

One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

Name of disaster impacted by:

Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

I was impacted by a significant network change with my current plan and was notified on (insert date): ____ ____/____ ____/____ ____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Race/Ethnicity Questionnaire

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- Hispanic or Latino/a/x Central American
- Hispanic or Latino/a/x Mexican
- Hispanic or Latino/a/x South American
- Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- Guamanian or Chamorro
- Marshallese
- Communities of the Micronesian Region
- Native Hawaiian
- Samoan
- Tongan
- Other Pacific Islander

Other

- Other
- I don't know.
- I don't want to answer.

American Indian or Alaska Native

- American Indian
- Alaska Native
- Canadian Inuit, Metis, or First Nation
- Indigenous Mexican, Central American, or South American

White

- Caucasian/White (no national affiliation)
- Eastern European/Slavic
- Western European
- Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- Middle Eastern
- North African

Black or African American

- African American
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- Afro-Latinx/Bi-racial/Other
- Other Black

Asian

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

Yes (please specify): _____

No: I do not have just one primary racial or ethnic identity.

No: I identify as Biracial or Multiracial.

N/A: I only checked one category above.

N/A: I don't know.

N/A: I don't want to answer.

What is your preferred spoken language?

- | | | | |
|--|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Cantonese | <input type="checkbox"/> French | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Decline/Unknown |
| <input type="checkbox"/> Chinese - Other | <input type="checkbox"/> Russian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> German | <input type="checkbox"/> Korean | |

What is your preferred written language?

- | | | | |
|----------------------------------|---|----------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Russian | <input type="checkbox"/> N/A: I don't know. |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Simplified Chinese | <input type="checkbox"/> Other | <input type="checkbox"/> N/A: I don't want to answer. |

Gender

- Male
- Female
- Other

How do you identify?

- Transgender Male
- Transgender Female
- Non-binary
- Other