healthfirst®
Health Insurance for New Yorkers

Enrollment Request Short Form Instructions

Use this form if you are changing from one Healthfirst Medicare Advantage plan to another. This form cannot be used to enroll in a Healthfirst Medicare Advantage plan for the first time.

Section 1 | Member Information

- Fill out this section completely, and please use the same name that appears on your current Healthfirst Member ID card.

Section 2 | Plan Information

- Fill in the name of the Healthfirst Medicare Advantage plan you're currently enrolled in, the new plan you'd like to change to, and the monthly premium associated with each plan. If you're unsure of plan names or premium amounts, you can find this information on our website at **healthfirst.org/medicare-long-term-care-plans**.

Section 3 | Your Primary Care Provider (PCP)

- Please provide the name and contact information of your Primary Care Provider (PCP), if you have one. You can find PCP information at **HFDocFinder.org**. Healthfirst will assign you a PCP if you do not choose one. You can change your assigned PCP at a later date if you wish.
- The items in this section are optional — you can't be denied coverage because you don't fill them out.

Section 4 | Other Information

- We want to make sure your plan materials are easy to read and in a language you understand. Please select your preferred language and/or format. We also want to know if you would like your plan materials sent to you in an electronic format.
- The items in this section are optional — you can't be denied coverage because you don't fill them out.

Section 5 | Your Plan Premium

- If your plan has a monthly premium, select your preferred premium payment method. You can choose to receive the statement each month and send us your payment by check, set up automatic deductions to have the premium deducted from your monthly Social Security or Railroad Retirement Board (RRB) benefit check, or pay online using your checking/savings account or credit/debit card. If you do not select a payment option, you will automatically receive your statement in the mail each month.
- Your premium amount may be reduced or waived if you are receiving Low Income Subsidy (LIS) or Extra Help. Please note that not all Healthfirst Medicare Advantage plans will have a plan premium.

Section 6 | Read and Sign

- It's important to read and understand the information in this section before signing and dating the form. Your signature authorizes Healthfirst to make changes to your coverage described in this form.

Send the completed form by mail or fax to:

Healthfirst Medicare Plan
P.O. Box 5193, New York, NY 10274-5193
Fax: 1-212-801-3250

Did you know that our forms are also available online? Log in to your secure Healthfirst account at **MyHFNY.org** to get the most out of your Healthfirst plan!

If you have any questions or need additional help, please call the Member Services phone number on the back of your Member ID card.

Coverage is provided by Healthfirst Health Plan, Inc. Healthfirst Health Plan, Inc. offers HMO plans that contract with the Federal Government. Enrollment in Healthfirst Medicare Plan depends on contract renewal.

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Enrollment Request Short Form

Please print all information in ink. Mail original copies to **Healthfirst Medicare Plan, P.O. Box 5193, New York, NY 10274-5193**.

If you are changing from one Healthfirst Medicare Advantage plan to another, you should use this form. This form cannot be used to enroll in a Healthfirst Medicare Advantage plan for the first time.

Section 1 | Member Information

First Name	Middle Initial	Last Name
Member ID		

Home Phone Number	Cell Phone Number		
Permanent Street Address (don't enter a P.O. Box)	City	State	Zip Code
Mailing address, if different from your permanent address (P.O. Box allowed)	City	State	Zip Code

Section 2 | Plan Information

I am currently a member of the _____ Plan with **Healthfirst**, with a monthly premium of $ _____.

I would like to change to the _____ Plan with **Healthfirst**. I understand that this plan has different health benefits and a monthly premium of $ _____.

If changing to Healthfirst Signature (HMO), please **select one of the following Choice Extras benefits:**

◯ Dental deductible waiver ◯ Over-the-counter (OTC) allowance ◯ Transportation

For more information on Healthfirst Signature (HMO) Choice Extras benefits, please see the plan Summary of Benefits.

If you are switching to the Healthfirst Life Improvement Plan or Healthfirst CompleteCare, you must also meet these additional Special Needs requirements.

Healthfirst Life Improvement Plan (HMO SNP)

- You must have full Medicaid benefits or be eligible for Medicare cost-sharing assistance under Medicaid

Healthfirst CompleteCare (HMO SNP)

- You must have full Medicaid benefits
- You must be 18 years of age or older
- You must be eligible for a nursing home level of care at time of enrollment, using the Uniform Assessment System (UAS)
- You must be capable, at the time of enrollment, of returning to or remaining in your home and community without jeopardy to your health and safety
- You are expected to require at least one (1) of the following Community-Based Long-Term Care Services (CBLTCS) covered by Healthfirst CompleteCare for more than 120 days from the effective date of enrollment:
  - nursing services in the home
  - therapies in the home
  - home health aide services
  - personal care services in the home
  - adult day healthcare
  - private duty nursing
  - Consumer Directed Personal Assistance Services

NY State Medicaid CIN Number (if applicable) _____

Section 3 | Your Primary Care Provider (PCP)

Healthfirst will assign you a PCP if you do not choose one.

Name of Primary Care Provider (PCP): _____

Primary Care Provider (PCP) Phone Number: _____

Primary Care Provider (PCP) Identification Number: _____

Section 4 | Other Information

1. I want to receive my plan documents (such as my Evidence of Coverage, Annual Notice of Change, and other plan materials) through email communications from Healthfirst. I understand that I may opt out at any time and receive hard copies of my Healthfirst Medicare plan documents by calling Healthfirst.
   Email address: _____
2. Select one if you want us to send you information in a language other than English. ◯ Spanish ◯ Chinese
3. Select one if you want us to send you information in an accessible format. ◯ Braille ◯ Large print
   Please contact Healthfirst Medicare Plan at **1-888-260-1010** if you need information in an accessible format other than what's listed above. Our office hours are 8am–8pm: 7 days a week (Oct.–Mar.); Monday to Friday (Apr.–Sept.). TTY users can call **1-888-542-3821**.
4. Do you work? ◯ Yes ◯ No
5. Does your spouse work? ◯ Yes ◯ No

Section 5 | Your Plan Premium

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Healthfirst Medicare Plan the Part D-IRMAA.

Please select a premium payment option:

◯ Receive a statement and pay by check made out to Healthfirst Health Plan, Inc.

◯ Automatic deduction from your monthly Social Security or RRB benefit check.

◯ I get monthly benefits from: ◯ Social Security ◯ RRB
(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 statement for your monthly premiums.)

◯ Pay online using checking/savings account or credit/debit card. Register, or log in to, your secure Healthfirst account at MyHFNY.org and click "Pay Your Bill".

Section 6 | Read and Sign

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Healthfirst Medicare Plan, he/she may be paid based on my enrollment in Healthfirst Medicare Plan.

Release of Information:

By joining this Medicare Advantage Plan, I agree that Healthfirst Medicare Plan may release my information to Medicare, other health plans, and healthcare providers for treatment, payment, and healthcare operations. I also agree that my healthcare providers may release my information to Healthfirst Medicare Plan and other healthcare providers for treatment, payment, and healthcare operations. I also agree that the information released for treatment, payment, and healthcare operations may include HIV, mental health, or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent. I also acknowledge that Healthfirst Medicare Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that when my Healthfirst Medicare Plan coverage begins, I must get all of my medical and prescription drug benefits from Healthfirst Medicare Plan. Benefits and services provided by Healthfirst Medicare Plan and contained in my Healthfirst Medicare Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Healthfirst Medicare Plan will pay for benefits or services that are not covered.

Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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 form and

2) documentation of this authority is available upon request from Medicare.

Member's or Authorized Representative's Signature: _____ Today's Date: _____

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

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

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Date Received: _____ Plan Code: _____ Sales Rep: _____ Employee ID #: _____

Group Name: _____ Group #: _____ QMB ___ QMB+ ___ SLMB ___ SLMB+ ___ QI-1 ___ QDWI ___ FBDE ___

Name of Staff Member (if assisted in enrollment): _____

Effective Date of Coverage: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Coverage is provided by Healthfirst Health Plan, Inc. Healthfirst Health Plan, Inc., offers HMO plans that contract with the Federal Government. Healthfirst Medicare Plan has a contract with New York State Medicaid for Healthfirst CompleteCare (HMO SNP) and a Coordination of Benefits Agreement with the New York State Department of Health for the Healthfirst Life Improvement Plan (HMO SNP). Enrollment in Healthfirst Medicare Plan depends on contract renewal. Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY 1-888-867-4132). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY 1-888-542-3821)。

