healthfirst®
Health Insurance for New Yorkers

Short Enrollment Request Form Instructions

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

Section 1 | Member Information

- Fill out this section completely so we can locate you in our system. 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 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 **https://healthfirst.org/health-insurance/medicare-plans/**.
- Please also provide the name and contact information for your Primary Care Provider (PCP), if you have one. You can find PCP information at **www.HFDocFinder.org**. If you leave this section blank or your PCP is not in our network, we will automatically assign a PCP for you. You can change your assigned PCP at a later date if you wish.

Section 3 | Preferred Material Language and Accessible Format

- 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.

Section 4 | Your Plan Premium

- Select your preferred premium payment method (if your plan has a monthly premium). 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 Plans will have a plan premium.

Section 5 | 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 **www.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 located on the back of your Member ID card. For in-person assistance, you can visit one of our Healthfirst Community Offices. Hours and locations are available online at **www.Healthfirst.org/healthfirst-community-office**.

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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Short Enrollment Request 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 plans within Healthfirst Medicare Plan, you should use this form. This form cannot be used to enroll in Healthfirst Medicare Plan for the first time.

Section 1 | Member Information

First Name	Middle Initial	Last Name		
Member ID	NY State Medicaid CIN Number (if applicable)			
Home Phone Number		Cell Phone Number		
Email Address (Optional)				
Permanent Street Address (P.O. Box is not allowed)		City	State	Zip Code
Mailing Address (only if different from your permanent street address)		City	State	Zip Code

Section 2 | Plan Information

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

I would like to change to the _____ Plan in **Healthfirst Medicare Plan**.

I understand that this plan has different health benefits and a monthly premium of $ _____.

Name of Primary Care Provider (PCP): _____

Primary Care Provider (PCP) Phone Number: _____

Primary Care Provider (PCP) Identification Number: _____

Section 3 | Preferred Material Language and Accessible Format (where available)

◯ English ◯ Spanish ◯ Chinese ☐ Braille ☐ Large Print

Please contact Healthfirst Medicare Plan at **1-888-260-1010** if you need information in an accessible format or language other than those listed above. Our office hours are 7 days a week, 8am–8pm. TTY users should call **1-888-542-3821**.

Section 4 | Your Plan Premium

If you have a monthly plan premium, you can pay it (including any late enrollment penalty that you currently have or may owe) by mail each month.

You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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 the RRB.

DO NOT pay Healthfirst Medicare Plan the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 for this benefit. 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 statement each month.

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Section 4 | Your Plan Premium

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 5 | Read and Sign

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 Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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 Health 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. This consent covers me and any of my family members for whom I may legally provide consent. I also acknowledge that Healthfirst Medicare Plan 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. 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. 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 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 beginning on the date Healthfirst Medicare Plan coverage begins, I must get all of my healthcare from Healthfirst Medicare Plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Healthfirst Medicare Plan and other services contained in my Healthfirst Medicare Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HEALTHFIRST MEDICARE PLAN WILL PAY FOR THE SERVICES.

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: _____

FOR HEALTHFIRST USE ONLY

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

Group Name: _____ Group #: _____ Select

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

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

