WELLCARE NEW YORK MEDICAID ADVANTAGE HEALTH PLAN ENROLLMENT FORM

◯ Mr. ◉ Mrs. ◯ Ms. Last Name:

First Name: Middle Initial:

Birth Date: M M | D D | Y Y Y Y Sex: ◯ M ◯ F Social Security Number: - -

Medicare Number: - - - Phone Number: ( ) -

Medicare App Date: M M | D D | Y Y Y Y Medicaid Client ID Number (CIN):

Select the county of your permanent address: ◯ Albany ◯ Broome ◉ Erie ◯ Monroe ◯ Niagara ◯ Oneida ◯ Orange ◯ Rensselaer ◯ Rockland ◯ Saratoga ◯ Schenectady ◯ Ulster

I am enrolling in the WellCare Medicaid Advantage Plan: LIBERTY (NY) Effective Date: M M | D D | Y Y Y Y

Members must disenroll from other Medicaid Advantage Plans **prior** to enrolling in LIBERTY Medicaid Advantage Health Plan.

The information that I have given in my application is true to the best of my knowledge.

I understand enrollment in Medicaid Advantage is voluntary. I have been told the rights and benefits that I will have as a member of Medicaid Advantage and the conditions of participation.

I understand that: I must be enrolled in the same health plan's Medicare Advantage product to enroll or stay enrolled in Medicaid Advantage, and I cannot be eligible for a monthly spend-down program with my Local Department of Social Services (LDSS). To the best of my understanding, I do not currently participate in a monthly spend-down program and I believe that I am eligible for Medicaid Advantage.

I have submitted an application to enroll in the WellCare Medicare Advantage Plan.

I consent to the release of any medical information about me:

- By my primary care provider (PCP), by any other health care provider or by the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me, as reasonably necessary, for my health plan or my providers to carry out treatment, payment or health care operations. This may include HIV/AIDS, mental health or alcohol and substance abuse information to the extent permitted by law. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to SDOH and other authorized federal, state and local agencies for purposes of administration of the Medicaid and/or Medicare programs; and
- By my health plan to other persons or organizations, as reasonably necessary, for my health plan to carry out treatment, payment or heath care operations.

I know that I can revoke this consent at any time by notifying the health plan in writing, except that this would not apply to information that has already been released.

I understand that other federal, state and local laws may also protect the confidentiality of my personal health information.

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 and 2) documentation of this authority is available upon request by WellCare Health Plans or Medicare.

Signature: _____ Today's Date: M M | D D | Y Y Y Y

If you are the authorized representative, you must sign above and print your name below:

Name: _____ Producer ID#:

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