MEDICARE D-SNP

2027

Enrollment Application

Highmark Health Options Duals (HMO D-SNP)

West Virginia

Apply with this form, online or by phone. If you have any questions, we're here to help!

www.highmark.com/hhoduals/wv

1-844-278-8453
(TTY 711)

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

Highmark Health Options Duals offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark Health Options West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield.

OMB No. 0938-1378
Expires: 12/31/2026

MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 and December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Fill out this form online at **www.highmark.com/hhoduals/wv** or mail your completed and signed form to:

Highmark Health Options Duals WV
Attn: Enrollment
PO Box 890032
Camp Hill, PA 17089-0032

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Highmark Health Options Duals WV at 1-844-278-8453.
TTY users can call 711.
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En espanol: Llame a Highmark Health Options Duals WV al 1-844-278-8453 (los usuarios de TTY pueden llamar 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en espanol y un representate estara disponible para asistirle.

Individuals experiencing homelessness:

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that are not about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 — All fields on this page are required unless marked as optional

Please check which plan you want to enroll in:

☐ **Highmark Health Options Duals (HMO D-SNP)**
$0 per month

First Name **Last Name** **Middle Initial (optional)**

Birth Date M M / D D / Y Y Y Y

Sex ☐ M ☐ F

Phone Number ( )

Social Security Number (optional)

Permanent Residence Street Address (Don't enter a PO Box except for indviduals experiencing homelessness, a PO Box may be considered your permanent residence address):

City **County** **State** **ZIP Code**

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

Street Address

City **State** **ZIP Code**

Your Medicare information

Medicare Number Please provide your Medicare number as shown on your red, white and blue Medicare Health Insurance card.

_ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Highmark Health Options Duals?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage:

Section 2 — All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other Language _____ (write in)

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

☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Highmark Health Options Duals at 1-844-278-8453 if you need information in an accessible format or language other than what is listed above. TTY users should call 711. Our office hours are:

October 1 – March 31	**8 a.m. to 8 p.m., 7 days a week**
April 1 – September 30	**8 a.m. to 8 p.m., Monday – Friday**

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide Medicaid number: _____

List your primary care physician (PCP), clinic, or health center:

_____

Address and/or phone number of primary care physician (PCP), clinic, or health center:

_____

☐ I am a current patient of this provider.

Please provide your e-mail and/or phone number if you'd like communications related to health education, reminders, and other information.

E-mail: _____ Phone number: _____

These emails may include sensitive health information specific to your needs. If you opt in to receive emails and/or text messages, there is a chance that emails and/or texts sent to you could be monitored, intercepted, read, and/or changed by an unauthorized third party before reaching your email inbox, and that it is possible that information intended for you could go to the wrong person or that your electronic accounts could be hacked. By opting in, you understand and accept these risks.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§422.50 and 422.60 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.

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.

New to Medicare or a Change To Your Coverage

- ❑ I am making my annual enrollment period election (October 15 - December 7).
- ❑ I am new to Medicare.
- ❑ I recently involuntarily lost my creditable prescription coverage ("creditable" means coverage as good as Medicare's). I lost my drug coverage on _____ (insert date).
- ❑ I am leaving or have left employer or union coverage on _____ (insert date).
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

Recent Change in Residence

- ❑ I recently moved or plan to move outside of the service area for my current plan, or I recently moved or plan to move and this plan is a new option for me _____ (insert move date).
- ❑ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on _____ (insert date).
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home).

  I moved/ will move into/ out of the facility on _____ (insert date).
- ❑ I recently obtained lawful presence status in the U.S. I got this status on _____ (insert date).
- ❑ I recently was released from incarceration. I was released on _____ (insert date).

Attestation of Eligibility for an Enrollment Period

Change in Income or Special Needs/Plan Qualifications

- ❑ 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 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 belong to a pharmacy assistance program provided by my state.
- ❑ I recently left a PACE plan (Program of All-Inclusive Care for the Elderly) on _____ (insert date).
- ❑ I was enrolled in a Dual Special Needs Plan (D-SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the D-SNP on _____ (insert date).
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ 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 recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, lost Medicaid) on _____ (insert date).
- ❑ This is my first time for Part B Entitlement.
- ❑ In the last 12 months, I left a Medigap policy to join a Medicare Advantage Plan* for the first time (*Medicare Advantage plan with prescription drug coverage).
- ❑ I have been on Medicare but just turned 65 or will be turning 65 in the next three months.
- ❑ My current plan was placed into Receivership by CMS due to financial difficulties.
- ❑ I am within the 4th to 7th month of my initial election period.

Other Reason

- ❑ I am in a plan that is identified as a consistent poor performer.
- ❑ 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.
- ❑ I am enrolling in a 5-Star Medicare plan.
- ❑ None of the above apply.

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Highmark Health Options Duals Medicare Advantage plan.
- By joining this Medicare Advantage plan, I acknowledge that Highmark Health Options Duals 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 above).
- I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 when my Highmark Health Options Duals coverage begins, I must get all of my medical and prescription drug benefits from Highmark Health Options Duals. Benefits and services provided by Highmark Health Options Duals and contained in my Highmark Health Options Duals "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Highmark Health Options Duals will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.

Signature **Today's Date**

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

Name

Address

Phone Number **Relationship to Enrollee**

( )

Agent, Broker, or Third Party Use Only

Relationship to Enrollee:

- ❑ Agent
- ❑ Broker
- ❑ SHIP Counselor
- ❑ Authorized Representative
- ❑ Other (Third Party)

Name: _____

NPN (required for Agents/Brokers): _____

Effective Date of Coverage: _____

Date Received: _____

Highmark Health Options Duals complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. Highmark Health Options Duals does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Health Options Duals provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Health Options Duals provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Highmark Health Options Duals Member Services at 1-833-957-0025 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m.

If you believe that Highmark Health Options Duals has failed to provide these services or discriminated against you in another way because of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Health Options Duals or the WV Human Rights Commission by mail, phone, or fax.

Highmark Health Options Duals
Attn: Appeals and Grievances
P.O. Box 890416
Camp Hill, PA 17089-0416
1-855-430-9852 (TTY: 711)
Fax: 1-833-560-1828

WV Human Rights Commission
1321 Plaza East, Room 108A
Charleston, WV 25301
304-558-2616
Fax: 304-558-0085
hho.fyi/wv-hrc

If you need help filing a complaint, Highmark Health Options Duals and the WV Human Rights Commission are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights online at OCRPortal.hhs.gov, and by mail, phone, or email:

U.S. Department of Health and Human Services
200 Independence Avenue SW
HHH Building Room 509F
Washington, DC 20201
1-800-368-1019 (TTY: 1-800-537-7697)
OCRMail@hhs.gov

A printable version of the complaint form is available at hho.fyi/complaint-form.

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West Virginia: 1-844-278-8453 (TTY: 711)

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili.

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभाषे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이