DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Action Request Transmittal

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Authorized Signature

Number: OMAP-AR-05-002

Issue Date: 06/23/2005

Topic: Medical Benefits

Due Date: 06/23/2005

Subject: Medicare Modernization Act - OHP Form Changes

Applies to:

DHS staff and others identified on the SPD, CAF, OMHAS and OMAP transmittal lists

Action Required:

1) At initial enrollment or recertification, eligibility workers must send the OHP 7208M (Medicare Advantage Election) form to new dual-eligible clients with *both Medicare A & B coverage* who are enrolled in an OMAP Medical Plan that has a corresponding Medicare Advantage plan. The client must complete and return the form to the OMAP Medical Plan within 30 days from the date of enrollment.

2) Workers must recycle existing stock of the OHP 7208M and OHP 7209 (Request to Terminate Insurance) forms, and only use the 2005 versions. These forms are on the OFDM Forms Server at http://www.dhs.state.or.us/admin/forms/index.html (click on "Find a Form") and will be available to order from the Forms Distribution Center in July.

Reason for Action:

1) Starting June 1, 2005, many OMAP Medical Plans will offer Medicare Managed Care Plans in new service areas. Medicare client enrollment into these plans is limited to dual-eligible clients with both Medicare A & B coverage. Clients who are enrolled in an OMAP Medical Plan, which also offers a Medicare Managed Care plan, must be enrolled in both plans.

   - A list of the start dates for the various plans follows. After these start dates, new dual-eligible Medicare A & B clients must complete the OHP 7208 M as outlined above.
   - Plans will be responsible for the 7208M form for the initial enrollment of all ongoing

clients this summer and fall. They will receive the forms from the client and answer any client inquiries concerning Medicare Advantage plans or enrollment in these plans.

2) As part of the Medicare Modernization Act (MMA), the Medicare Managed Care Plans are now "Medicare Advantage" plans (not "Medicare + Choice" plans). OMAP has revised the OHP 7208M and OHP 7209 forms to reflect this change. A copy of each form follows.

OMAP will revise their Worker Guide effective July 1, 2005 to include information about Medicare Advantage Plans and instructions for these forms.

If you have any questions about this information, contact:

Contact(s):	Patricia Roller, MMA Coordinator, OMAP		
Phone:	503-947-5128	**Fax:**	503-947-5221
E-mail:	patricia.roller@state.or.us		

DHS Oregon Department of Human Services

OHP Medicare Advantage Plans

For specific information on the service areas available for each plan, refer to the KSEL screen, or go to OMAP's Comparison Charts at http://www.oregon.gov/DHS/healthplan/data_pubs/planlist/main.shtml.

Plan Name	Service Area - County
Existing Medicare Advantage Plans	***= Service areas limited by ZIP code or city.***
Central Oregon Independent Health Services (COIHS)	Grant, Lake, Wheeler, Harney, Crook, Jefferson, Klamath*, Deschutes, Hood River, Wasco, Sherman
Kaiser Permanente	Marion*, Polk*, Multnomah*, Clackamas*
Providence	Clackamas, Washington*, Multnomah, Yamhill*
Starting June 1, 2005	***= Service areas limited by ZIP code or city.***
Cascade Comprehensive Care	Klamath
Doctors of the Central Oregon Coast (DOCS)	Coos
Douglas County Individual Practice Association (DCIPA)	Douglas
Intercommunity Health Network (IHN)	Linn & Benton
Mid Rogue Independent Physician Association (MRIPA)	Jackson*, Josephine*, Douglas*
Starting September 1, 2005	***= Service areas limited by ZIP code or city.***
FamilyCare	Clackamas*, Jackson*, Josephine*, Morrow, Multnomah, Umatilla*, Washington*
Starting January 1, 2006	***= Service areas limited by ZIP code or city.***
CareOregon	Clackamas, Clatsop, Columbia, Coos, Douglas, Jackson*, Klamath*, Marion, Morrow, Multnomah, Polk, Umatilla*, Washington, Yamhill
Marion-Polk Community Health Plan (MPCHP)	Marion, Polk, Yamhill, Benton*, Linn*, Clackamas*

For clients enrolled with these plans:

Dual-eligible clients with both Medicare A and B coverage must complete the OHP 7208M (Medicare Advantage Election Form).

Clients must return the completed form to their managed care plan within 30 days of new enrollment or recertification, or the plan will request disenrollment of the client.

Oregon HEALTH PLAN

DHS
Oregon Department of Human Services

Office of Medical Assistance Programs

Medicare Advantage Plan Election

Personal Information				
Name			Phone ( )	
Street Address (permanent residence)			Apartment #	
City, State, ZIP				County
Date of Birth	Sex M F	Social Security Number	Medicare Claim Number	

Important Information		
Your Primary Care Provider (Last, First)	Part A – Hospital Ins. Effective Date	Part B – Medical Ins. Effective Date
Name of the Medicare Advantage Plan you are choosing	Name of Your Current OMAP Medical Plan	

Do you have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have you received a kidney transplant within the last 36 months? ❑ Yes ❑ No

If yes, you cannot enroll in a Medicare Advantage Plan unless you are already enrolled in the plan as a commercial member.

Are you currently a resident in an institution such as a nursing facility, foster care home or residential care, or assisted living facility? ❑ Yes ❑ No
This will not affect your Medicare Advantage Plan enrollment.

If yes, institution name: _____

Address: _____

Phone: _____ Date of Admission _____

Prime #	Branch#	Worker ID/Phone #	OMAP Medical Plan Eff Date	Mailed to OMAP Medical Plan On

Do you, either on your own or through your spouse, have any health coverage other than Medicare, such as private insurance, Workers Compensation, or VA benefits? ❑ Yes ❑ No

If yes, what kind? _____

Name of insurance:_____

Read and initial each of the following statements:

____ I understand that my Medicare Advantage Plan will send me confirmation of my enrollment.

____ I understand that I must maintain my Medicare Part A and B coverage. If applicable, the State of Oregon will continue to pay my Part A and B premiums, co-insurances and deductibles.

____ I understand that I can only be enrolled in one Medicare Advantage Plan at a time. I understand that if I am currently enrolled in a Medicare Advantage Plan and then enroll in a new Medicare Advantage Plan, I will automatically be disenrolled from my current Medicare Advantage Plan.

____ I understand that I may disenroll from my Medicare Advantage Plan at any time by sending a written request to either:
- My Medicare Advantage Plan, or
- The Centers for Medicare and Medicaid Services (CMS).

____ I understand that I must receive health care from my Medicare Advantage Plan's providers.

____ I understand that I have the right to appeal service and payment denials made by my Medicare Advantage Plan.

____ I understand that it is my responsibility to inform my Medicare Advantage Plan before permanently moving out of the service or continuation area. I understand that if I move permanently out of the services and continuation area, I will be disenrolled from my Medicare Advantage Plan.

Release of Information

I authorize the Centers for Medicare and Medicaid Services (CMS) to give information about my Medicare coverage to the Medicare Advantage Plan I have chosen. This information will be used by my Medicare Advantage Plan to confirm my entitlement to Medicare Hospital Insurance Benefits (Part A) and to Supplementary Medical Insurance Benefits (Part B) under Title XVII (the Medicare Program) of the Social Security Act.

I authorize my Medicare Advantage Plan and its providers to release to CMS or CMS' agents any information about me that is needed to administer Title XVIII of the Social Security Act.

Lock In

I understand that while I am enrolled in a Medicare Advantage Plan I must receive all of my health care services through that Medicare Advantage Plan with the exception of emergency or urgently needed out-of-area services. Emergency or urgently needed out-of-area services are covered anywhere in the United States and in certain hospitals in Mexico and Canada.

I understand that an Evidence of Coverage document (also known as a member contract or subscriber agreement) will be sent to me by my Medicare Advantage Plan once I am enrolled. The Evidence of Coverage document includes the services that are covered through my Medicare Advantage Plan and the rules I must follow to receive those services.

I understand that I am responsible for the payment of services that are not covered.

I understand that my signature certifies that I have read and understand the contents of this form.

Signature Date

Did someone help this client complete this form? ❑ Yes ❑ No

If yes, sign and date here: _____

Relationship to Client: _____

If the client is unable to sign, a court-appointed Legal Guardian or person having Durable Power of Attorney for Health Care (DPAHC) or designated in a written advance directive, or other, if authorized by state law, must complete the next page.

If the client signs with their mark or stamp, two witnesses must sign on the next page.

Signature by Mark

Did the client sign with a mark or stamp? ❑ Yes ❑ No

If yes, two witnesses are required to sign and date:

Witness #1 _____

Witness #2 _____

State Approved Signature

Did the client sign this form? ❑ Yes ❑ No

If no, complete the information below. The following information is required when the client is unable to sign. Write N/A if it doesn't apply.

The client was unable to sign this form because of the following physical limitations: _____

_____

_____

The client cannot give informed consent due to _____

_____

_____

The person signing for the client is (check the appropriate box and sign below):

- ❑ A court-appointed legal guardian with authority to make health care decisions - *attach a copy of guardianship papers*
- ❑ A person who has Durable Power of Attorney for Health Care (DPAHC) - *attach a copy*
- ❑ A person designated in a written advance directive - *attach a copy*, or
- ❑ A person authorized by state law to sign (spouse, parent, family member, or authorized agency worker)

Signature and date _____

Relationship to client_____

Phone _____

State of Oregon
Department of Human Services
Office of Medical Assistance Programs

Program	Branch	Case Number	Worker ID
Case Name			

Request to Terminate Insurance

To: _____
(Name of Insurance Company/Medicare Advantage Plan)

From: _____
Last First Middle

Address: _____

_____
City Zip Code County

Phone: _____ Date of Birth _____

Medicare Number : _____

Policy or Health Plan Number: _____

I request the health insurance/Medicare Advantage Plan I purchase through your company be ended effective:_____

I understand that your company will not pay any of my medical bills incurred after the actual termination date.

Medicare Advantage Plan Only: I understand I must continue to use the Medicare Advantage Plan named above until the effective date.

I am enrolling in: _____

Note: It may take Medicare a month to process your disenrollment. If Medicare denies bills they receive before you are disenrolled, ask your providers to resubmit these bills.

Signature: _____ Date:_____

If signer is not the client indicate
your relationship to client_____ Phone:_____

Agency Use Only **Complete fully before routing.**

Prime #	Branch #	Agency Contact	Contact Phone #

Distribution: White – Insurance/MAPD Yellow – OMAP/HIG Pink – Case File Blue – Client

HMO/Other Health Insurance Termination Guidelines:

1. Client completes the OHP 7209 to request termination of HMO membership or coverage by other health insurance.
2. Worker sends the OHP 7209 to the Medicare Advantage plan or insurance company. The form must arrive at the Medicare Advantage Plan/insurance office by the last working day of the month termination is to be effective.
3. Worker sends a copy of the OHP 7209 to the Health Insurance Group, OMAP, to correct the third-party resource computer file (ELGX/ELGT).
4. Do not use the AFS 415H in conjunction with the OHP 7209.