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Operations Section, DMAP

**Authorized Signature**

**Number:** DMAP-IM-06-174

**Issue Date:** 10/11/2006

**Topic:** Medical Benefits

**Subject:** Announcement to dual eligible clients enrolled in LIPA:

- ① informing them that LIPA is contracting with Medicare as a Medicare Advantage Plan, and
- ② providing an enrollment form, return envelope and instructions

**Applies to (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> All DHS Employees             | <input type="checkbox"/> County Mental Health Directors  |
| <input type="checkbox"/> Area Agencies on Aging        | <input type="checkbox"/> Health Services   |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities  |
| <input type="checkbox"/> County DD Program Managers    | <input checked="" type="checkbox"/> Other (please specify): <u>DHS staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists</u> |

**Message:**

DMAP is mailing the following announcement to dual eligible clients (clients with both Medicaid and Medicare coverage) who are enrolled in LIPA. The announcement:

- Informs clients that LIPA is now contracting with Medicare as a Medicare Advantage Plan, Trellium SNP, and
- Includes a Medicare Plan Election form and return envelope.

*If you have any questions about this information, contact:*

|                    |  |
|--------------------|--|
| <b>Contact(s):</b> | <b>Christina Jaramillo, MMA Implementation Coordinator</b> |
| <b>Phone:</b>      | <b>503-947-5281</b>  |
| <b>E-mail:</b>     | <b>Fax:</b>  |

# Important Information About Your Medical Plan

This information is for any member of your household who has **both** Medicare and Medicaid (Oregon Health Plan) coverage.

Your current OMAP Medical Plan, Lane Individual Practice Association (LIPA), is contracting with Medicare to also become a Medicare Advantage Plan called Trillium Advantage SNP. If you enroll in Trillium it will **not** change your health care coverage. Your Medicare Prescription Drug Plan will change to Trillium.

## You Have a Choice

- If you want to enroll in Trillium:
  - ✓ Fill out the *Medicare Advantage Plan Election* form enclosed with this announcement. Write Trillium SNP as the name of the Medicare Advantage Plan you are choosing.
  - ✓ Sign and mail the form, using the envelope we've included, ***no later than December 15, 2006.***

Trillium will send you information about itself and tell you when your membership begins.

Being enrolled in both LIPA and Trillium will make it easier to coordinate your health care and make sure you receive all of the services covered by Medicare **and** the Oregon Health Plan.

- If you do not complete and return the *Medicare Advantage Election* form you will not be enrolled in Trillium. **However, LIPA may decide not to provide Oregon Health Plan (OHP) medical coverage for you anymore.**

If LIPA does not provide your OHP medical coverage, the Office of Medical Assistance Programs will continue to pay for all of your other covered health services on a fee-for-service basis, by having you go to any provider who will take your OMAP Medical Care ID.

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## Questions?

- ☎ If you have any questions about this information, call Trillium at: (541) 431-1950 (direct), 1-800-910-3906 (toll-free), 1-866-234-4578 (TTY) **or** LIPA at 1-877-600-5472.
- ☎ If you need this information in a larger print size or different format, call your worker.
- ☎ If you need help filling out the *Medicare Advantage Plan Election* form, call your worker.

## Medicare Advantage Plan Election

| Personal Information                                    |              |  |   |  |
|---|--------------|--|---|--|
| Name  |              |  | Phone<br>(    )                           |  |
| Street Address (permanent residence)                    |              |  | Apartment #                               |  |
| City, State, ZIP  |              |  | County                                    |  |
| Date of Birth<br>(__/__/____)                           | Sex<br>M   F | State Identifier Number                  | Medicare Claim Number                     |  |
| Important Information                                   |              |  |   |  |
| Your Primary Care Provider (Last, First)                |              | Part A – Hospital Ins.<br>Effective Date | Part B – Medical<br>Ins. Effective Date   |  |
| Name of the Medicare Advantage Plan<br>you are choosing |              |  | Name of Your Current OMAP<br>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.

If you answered “yes” to this question and you do not need regular dialysis anymore, or have had successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

| Prime # | Branch# | Worker ID/Phone # | OMAP Medical Plan<br>Eff Date | Mailed to OMAP Medical<br>Plan On |
|---------|---------|-------------------|-------------------------------|-----------------------------------|
|         |         |                   |                               |                                   |

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to your Medicare Advantage Plan?  Yes  No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: \_\_\_\_\_

ID# / Group# for this coverage: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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**I Understand the following to be true:**

- My Medicare Advantage Plan will send me confirmation of my enrollment.
- 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 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 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 must receive health care from my Medicare Advantage Plan's providers.
- I have the right to appeal service and payment denials made by my Medicare Advantage Plan.
- 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 by Medicare.

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

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Signature

Date

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**If the client is unable to sign, a court-appointed Legal Guardian or person having a Health Care Representative 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 \_\_\_\_\_

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## State Approved Signature

Did someone help this client complete this form?

Yes  No

If yes, please write your name and phone number:

\_\_\_\_\_  
Signature and date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

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 a Health Care Representative - 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 number: \_\_\_\_\_