2024
Providence Medicare Advantage Plans Plan Change Form

Providence Medicare Advantage Plans

Dear Providence Medicare Advantage Plans Member:

To make a change in the Medicare Advantage plan you have with Providence Medicare Advantage Plans, fill out the attached plan change form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us.

You can change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 – March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you select another plan and we receive your completed selection form by the end of any month, your new benefit plan will generally begin the first of the following month. Your monthly plan premium will be determined based on your plan selection as listed below. You may continue to see any Providence Medicare Advantage Plans primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2024 Summary of Benefits for the available options online.

If you have any questions, please call Providence Medicare Advantage Plans at **503-574-8000** or **1-800-603-2340 (TTY users should call 711)**. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you,

Providence Medicare Advantage Plans

Plan Change Form

DATE | LAST NAME | FIRST NAME | MI | MEMBER NUMBER

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX) | PHONE NUMBER

CITY | COUNTY (OPTIONAL) | STATE | ZIP CODE

EMAIL ADDRESS

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

STREET ADDRESS

CITY | STATE | ZIP CODE

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month. If this form is received during October 15 through December 7, the effective date will generally be the 1st of January.

Please check the appropriate box below:

☐ Providence Medicare Dual Plus (HMO D-SNP)*

Monthly Premium Amount: $0

Out-of-Pocket Max:
- In-Network: $8,850

Primary Care Provider visit:
- In-Network: 0% of the cost for each visit

Specialist visit:
- In-Network: 0% of the cost for each visit

Inpatient Hospital Coverage:
- In-Network: $0 copay for each benefit period

Emergency Care:
0% of the cost

Ambulance:
0% of the cost

*Providence Medicare Dual Plus (HMO D-SNP) is available to you if you have Medicare Part A and B, you have full Oregon Health Plan (OHP) Medicaid benefits, and you live in Clackamas, Multnomah or Washington County. You must continue to pay your Medicare Part B premium. The Part B premium is covered for full dual enrollees who are eligible for Providence Medicare Dual Plus (HMO D-SNP). Premiums, co-pays, co-insurance and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

OFFICE USE ONLY

NAME OF STAFF MEMBER/AGENT/BROKER (IF ASSISTED IN ENROLLMENT)	PLAN ID #	EFFECTIVE DATE OF COVERAGE
		____/____/____

☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____ ☐ Not Eligible _____ ____/____/____ DATE

PBP	TRAN. CODE	PREMIUMS	GROUP #	CONTRACT #

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

☐ Braille ☐ Large print ☐ Audio CD

Please contact Providence Medicare Advantage Plans at **1-800-603-2340 (TTY users should call 711)** if you need information in an accessible format or language other than English. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

SIGNATURE **TODAY'S DATE** __ __ /__ __/ __ __

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

NAME

ADDRESS

CITY COUNTY (OPTIONAL) STATE ZIP CODE

PHONE NUMBER RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

AGENT USE ONLY

AGENT NAME DATE __ __ /__ __/ __ __

NPN # REQUESTED DATE OF COVERAGE __ __ /__ __/ __ __

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.

- ☐ I am leaving employer or union coverage on (insert date): ____ ____/____ ____/____ ____
- ☐ 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 am enrolling during the Annual Enrollment Period (October 15-December 7).
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used): _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): ____ ____/____ ____/____ ____
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): ____ ____/____ ____/____ ____
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ 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 am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into the facility on (insert date): ____ ____/____ ____/____ ____
  I moved/will move out of the facility on (insert date): ____ ____/____ ____/____ ____
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): ____ ____/____ ____/____ ____
- ☐ 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 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.
  Name of disaster impacted by:

  _____

  Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

  _____
- ☐ I was impacted by a significant network change with my current plan and was notified on (insert date): ____ ____/____ ____/____ ____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at **1-800-603-2340** or **503-574-8000 (TTY users should call 711)** to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).