Providence
Medicare Advantage Plans

Home Visit Checklist

We are committed to ensuring you are getting all the Medicare benefit available. There are a lot of moving parts to Medicare, and the intent of this form is to help guide our conversation and confirm the important information was adequately explained to you.

Introduction			
Name/Business card provided	☐	Agent name & Agency name	☐

General Information	
Providence Health Assurance is an HMO, HMO-POS, and HMO SNP plan with Medicare and Oregon Health Plan contracts. Enrollment in Providence Health Assurance depends on contract renewal.	Members must reside in the service area Members must have Medicare Part A & B Members must continue to pay Medicare Part B premium DSNP – Member must have Medicaid with full dual designation

Plan Review			
HMO	☐	HMO-POS	☐
In-network	☐	Out-of-network*	☐
Referrals	☐		

Plan Premiums			
Plan Premium	☐	Dental Buy-up & Premiums	☐

Summary of Benefits			
Out-of-pocket maximum	☐	Inpatient Hospital Copay	☐
PCP copay	☐	Outpatient Surgery Copay	☐
Specialist copay	☐	Skilled Nursing Copay	☐
Emergency copay	☐	Urgent care copay	☐
Ambulance copay	☐	Worldwide Emergency & Urgent Care	☐

Embedded Supplemental Benefits			
Preventive Dental	☐	Routine Vision Exam & Hardware Allowances	☐
Fitness Membership	☐	Routine Hearing Exam & Hear Aids Benefit	☐
Mom's Meals	☐	Personal Emergency Response System	☐
Over-the-Counter	☐	Alternative Care	☐
Wig for hair loss related to Chemotherapy	☐	Non-Emergent Transportation	☐
Dental Flex card	☐	Other	☐

Medicare Part D Prescriptions			
Initial coverage limit	☐	Coverage gap	☐
TROOP	☐	Formulary	☐
Formulary	☐	Step Therapy	☐
Prior Authorizations	☐	Rx Deductible	☐
Copays/Coinsurance	☐	Network & Preferred Pharmacies	☐
Transition Process	☐	Reviewed current prescriptions	☐

PCP Selection			
In-Network	☐	Current Patient	☐

The person that is discussing plan options with you is ether employed or contracted with Providence Medicare Advantage Plans and may be compensated based on your enrollment in a plan. By signing this form, you acknowledge and agree the information above was adequately explained to you.
Note: Member signature is optional; cannot be required.

Beneficiaries Information & Agent Signature	
Beneficiary or Power of Attorney Name:	Date of Appointment:
Phone:	Beneficiary or Power of Attorney Signature:
Agent Name:	Agent National Producer Number (NPN):

*Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.