

VA's Beneficiary Initial Letter - opt-in notice

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services



<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<12 digit Medicaid ID number>

Dear <Name>:

Welcome to Commonwealth Coordinated Care!

You are receiving this letter because you have both Medicare and Medicaid benefits. Beginning March 1, 2014, you will have an opportunity to enroll in Commonwealth Coordinated Care, a new health care program designed to give you seamless, high quality care at a low cost or zero cost to you.

Commonwealth Coordinated Care is a combined Medicare and Medicaid plan that includes all the benefits you currently receive under Medicare and Medicaid, **PLUS** other additional benefits. Commonwealth Coordinated Care has one ID card and one phone number to call for assistance.

This new health plan provides coverage that includes:

- Your choice of doctors and other providers within the health plan's network who work together to give you the care you need;
- Prescription drugs;
- Long term care services and supports (including nursing facility care or EDCD waiver services)
- Person-centered care coordination; and,
- 24-hours/7 days a week phone number for assistance.

Enclosed is a brochure that lists the Commonwealth Coordinated Care health plans, which are referred to as Medicare Medicaid Plans or MMPs, and the benefits they offer to help you choose a plan that best meets your needs. Also enclosed is an enrollment application if you wish to submit this by mail. Please complete in its entirety and return to:

Commonwealth Coordinated Care

P.O. Box 2029
Richmond, VA 23219

What should I do now?

Beginning March 1, 2014, call your enrollment broker at 1-855-889-5243 (TTY: 1-800-817-6608), between 8:30 am to 6:00 pm Monday-Friday (translation services available), to discuss the health plan options available to you, including how you can keep your current Medicare Medicaid and prescription drug coverage.

Feel free to share this letter with a family member or someone who knows your healthcare needs. This information is available for free in other languages and formats like Braille or audio CD.

If you need help understanding information you get from plans or for free, personalized health insurance counseling, call your Virginia Insurance Counseling Assistance Program (VICAP) at 1-800-552-3402.

If you have questions about Medicare or need help with your Medicare options, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Keep a copy of this form for your records

Commonwealth Coordinated Care Enrollment Application Form

To join a Commonwealth Coordinated Care plan, you must have **Medicare Part A**, **Medicare Part B**, and **Medicaid**. You can also call the enrollment broker at 1-855-889-5243 (TTY: 1-800-817-6608), between 8:30 am to 6:00 pm Monday-Friday to join the Commonwealth Coordinated Care plan. The call is free. Translation services are available.

Choose a health plan:

- | | |
|--|--|
| <input type="checkbox"/> Healthkeepers, Inc. | <input type="checkbox"/> Virginia Premier Health Plan, |
| <input type="checkbox"/> Humana Health Plan | |

Tell us about yourself:

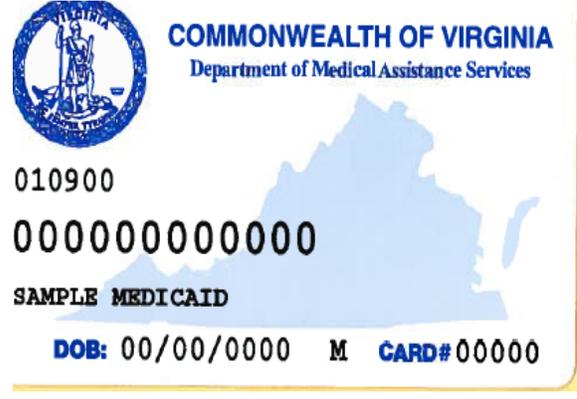
Name: (first, middle, last)			
Date of birth: (<u> </u> / <u> </u> / <u> </u> M M D D Y Y Y Y)		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Phone number: (<u> </u>) <u> </u> - <u> </u>	Another phone number: (<u> </u>) <u> </u> - <u> </u>	Email Address:	
Address where you live: (P.O. Boxes are not acceptable for address of residence)			
City:	State:	ZIP code:	County:
Address where you get mail (if different from where you live):			
City:	State:	ZIP code:	County (Optional):
Emergency contact name:		Emergency contact phone: (<u> </u>) <u> </u> - <u> </u>	
If you are not a native English speaker, you can call 1-855-889-5243 to get the form in a different language. TTY users should call 1-800-817-6608.			

Tell us where you usually get health services:

Name of your primary care provider, clinic or, health center:	Phone number: (____) ____ - _____
---	--

Tell us about your Medicare & Virginia Medicaid coverage:

Fill in your Medicare and Virginia Medicaid information below. You can find this information on your red, white, and blue Medicare card, or a letter from Social Security or the Railroad Retirement Board. Also, please put your 12 digit Virginia Medicaid ID number as it appears on the front of your card.

 MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number _____ Sex ____ _____ - _____ - _____ Is Entitled To _____ Effective Date _____ HOSPITAL (Part A) _____ MEDICAL (Part B) _____	 COMMONWEALTH OF VIRGINIA Department of Medical Assistance Services 010900 000000000000 SAMPLE MEDICAID DOB: 00/00/0000 M CARD#00000
---	---

Medicare Claim Number: _____ Medicaid ID Number: _____

Other personal information:

Do you have End-Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" and you've had a successful kidney transplant and/or no longer need regular dialysis, please attach a note from your doctor.	
Do you live in a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in the information below:	
Name of the facility:	Phone number: (____) ____ - _____

Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

Your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

Do you have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, fill in the information below:</i>	
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
Name of your plan <i>(and employer, if applicable)</i> :	Group number:
	ID number:
If you have comprehensive health coverage from an employer or union, you are not eligible for enrollment into the Commonwealth Coordinated Care Program at this time.	

Please read and sign below.

When you sign this form, it means that you understand:

<ul style="list-style-type: none">• Commonwealth Coordinated Care (CCC) has a contract with the federal government and with Virginia.• The health services you get with your new plan may be different than the services you had before.• I must keep Medicare Part A, Part B and Virginia Medicaid.• I can be in only one Medicare plan at a time.• By joining CCC plan, I will end my enrollment in another Medicare health or prescription drug plan.• I must tell Medicare and Virginia Medicaid about any prescription drug coverage that I have or may get in the future.• If I move, I need to tell the local Department of Social Services and the enrollment broker at 1-855-889-5243 (TTY: 1-800-817-6608), between 8:30am to 6:00pm Monday-Friday.• As a member of CCC plan, I have the right to appeal if I don't agree with CCC plan's decisions about payment or services.• The CCC plan doesn't usually cover people while they're out of the country.• On the date CCC plan coverage begins, I must get my health care from CCC plan doctors, except for emergency or urgently needed care, out-of-area dialysis or if I get CCC plan or State's approval to see other providers in some circumstances.• If I need to see a doctor or other provider who is not in CCC plan, I may need prior authorization or I may have to pay out-of-pocket for the services I get.	<ul style="list-style-type: none">• By joining CCC plan, I know that CCC plan may share my information with Medicare and Virginia Medicaid and other plans as necessary for treatment, payment, and health care operations.• I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll have access to my current drugs for at least 90 days, until I can switch to a different drug, and that I will have access to my current doctors for 180 days once I join CCC plan. I further understand that CCC plan has providers and pharmacies I must use to get health care services, except for non-routine, emergency situations.• I know that CCC plan may share my information including my prescription drug information with Medicare and Virginia Medicaid. They may release it for research and other purposes, as allowed by Federal statutes and regulations.• The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from the CCC plan.• My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Virginia Medicaid program.
--	---

Your signature:	Date:
If you are the authorized representative, you must provide the following information, sign, and date below:	
Name: _____ (Please Print)	Signature: _____
Address: _____	
Phone Number: (_____) _____ - _____	
Relationship to Enrollee: _____	
Today's Date: _____	

For more information, visit www.virginiacc.com. **If you have questions**, call the enrollment broker at 1-855-889-5243 Monday-Friday 8:30am - 6:00pm. TTY users should call 1-800-817-6608. The call is free. This information is available for free in other languages and formats like Braille or audio CD.