CMS Medicare Manual System
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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
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Exhibit 7
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Red italicized font identifies new materials.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2003
IMPLEMENTATION DATE: January 1, 2003

Table of Contents - Delete special note just above Table of Contents, add line item for new section Exhibit 4a, and change name for Exhibit 7.

Throughout - Revised text to consistently use the term "legal representative" in place of "authorized representative," or "member representative." (**Sections 20, 40.1, 40.6, 50.2.1, 50.4.1, 50.5 - not listed below unless that section had other changes too.**)

Section 10 - Definitions - Subsections:

"Completed Election" - Added language to Item 2 regarding CMS's proposed policy to not penalize beneficiaries who are, in fact, entitled when CMS' systems are not timely.

"Denial of Election" - added "enrolled in Part (B)" to indicate individual would be enrolled in Part B, not entitled to Part B.

"Election Form" - Added phrase "(or other CMS approved method, if available)"

"Evidence of Medicare Part A and Part B Coverage" - Added note regarding CMS's allowance of three business days after the end of the month to obtain verification or evidence of entitlement to Part A or enrollment in Part B.

"Medicare + Choice Organization (M+C organization)" - Miscellaneous punctuation correction.

Section 20 - Eligibility for Enrollment in Medicare + Choice Plans - In List Item 4, changed "legally authorized representative" to "legal representative".

Section 20.1 - Entitlement to Medicare Parts A and B - Inserted clarifying phrase "plan created under."

Section 20.2.1 - Background on ESRD Entitlement - Miscellaneous word change in second paragraph in the example.

Section 20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD - Miscellaneous word change in second paragraph.

Section 20.3 - Place of Permanent Residence - Correct miscellaneous typographical errors.

Section 20.4 - Completion of Enrollment Form - Added reference to Exhibit 3a, and added link in Web file.

Section 20.5 - Agreeing to Abide by Medicare + Choice Organization (M+C) - Corrected capitalization in section heading.

Section 20.7 - Eligibility and the Hospice Benefit - Added reference to Exhibit 4a, and added link in Web file.

Section 20.8 - Continuation of Enrollment Option - Miscellaneous word change in second paragraph.

Section 20.9 - Additional Eligibility Requirements for M+C Religious Fraternal Benefit (RFB) Plans - Miscellaneous word change in second paragraph.

Section 30.3.2 - OEP in 2005 - Updated dates in second, third, and fourth paragraph.

Section 30.5 - Effective Date of Coverage - In first paragraph, added sentence stating enrollment cannot be effective prior to date the form is signed.

Section 40 - Enrollment Procedures - Correct miscellaneous typographical error.

Section 40.1 - Format of Enrollment Forms - Inserted language throughout the section to clarify transfers from one plan to another within the same MCO.

Section 40.2 - Completing the Enrollment

Under "Entitlement Information," inserted two paragraphs regarding the allowance of 3 business days after an election form is received for an M+C organization to obtain evidence of entitlement to Medicare Part A and B.

Added a unnumbered, bulleted subsection, “Premiums Owed to the M+CO” allowing an M+CO to wait until payment is received to consider an enrollment "complete" if the individual was disenrolled for nonpayment previously.

Section 40.2.2 - When the Enrollment Form is Incomplete - Under "Entitlement Information," deleted last sentence of first paragraph and added "NOTE" paragraph regarding the allowance of three business days after an election form is received for an M+C organization to obtain evidence of entitlement to Medicare Part A and B.

Section 40.4.1 - Prior to the Effective Date of Coverage - Added references to new Exhibit 4a, and added link to Web file.

Section 40.4.2 - After the Effective Date of Coverage – Replaced the words "SEP or an ICEP" with the words "election period" in the first paragraph. Added hyperlinks to Exhibits 6, 6a, and 8 under subsection "Acceptance/Rejection of Enrollment".

Section 40.5.1 - Procedures After Reaching Capacity - Changed capitalization in sidehead subtitles

Section 40.6 - Enrollments Not Legally Valid - Miscellaneous word change.

Section 50.1 - Voluntary Disenrollment by Member - Corrected reference from "section 5.6" to "§50.8" in List Item Number 3, and change verb tense change under subsection "Requests Submitted via Internet".

Section 50.2.1 - Members Who Change Residence - Miscellaneous word change.

Section 50.3.2 - Disruptive Behavior - Spelled out the acronym "RO" to Regional Office.

Section 50.5 - Disenrollments Not Legally Valid - Miscellaneous word change.

Section 60.2.1 - Cancellation of Enrollment - In second paragraph, added instructions regarding submission of a disenrollment transaction when the M+CO organization has already transmitted an enrollment, but received a request for cancellation.

Section 60.2.2 - Cancellation of Disenrollment - In second paragraph, added instructions regarding submission of a disenrollment transaction when the M+CO organization has already transmitted an enrollment, but received a request for cancellation.

Section 60.3.2 - Reinstatements Due to Mistaken Disenrollment Made by Member - Deleted "then" from third paragraph, first sentence.

Section 60.4 - Retroactive Enrollments - Added references to new Exhibit 4a, and added link to Web file.

Section 60.6.1 - EGHP Retroactive Enrollments - Spelled the date out in the Example.

Appendices and Exhibits

Throughout - Various word, grammatical, capitalization, punctuation, and spelling changes and/or corrections.

In addition:

Appendix 1 - Summary of Notice Requirements - Added "4a" to "Notices" column as an available exhibit as a result of the new Exhibit 4A, and added "(no exhibit") to the "Notices" entitled, “Notice that Election Placed on Waiting List,” “Re-affirming Intent to Not Enroll,” and “Intent to Not Process Enrollment.”

Appendix 2 - Data Elements Required to Complete the Enrollment Form - Added requirements with respect to "Item #24" to Endnote 4, and added Endnote 3 and 4 back to Web file.

Exhibit 3 - Model Short Enrollment (or "Election") Form - Deleted last question above "Name of chosen Primary Care Physician (PCP), clinic, or health center (if required):___"

Exhibit 4a - Model Notice Acknowledge Receipt of Completed Enrollment Form - Enrollment in Another Plan Within the Same M+C Organization - added new exhibit.

Exhibit 7 - Model Notice for M+C Organization Denial of Enrollment - Changed name of exhibit.

Exhibit 10 - Attachment to Exhibit 9 (Model Disenrollment Form) - Deleted all explanatory paragraphs after beneficiary signature lines.

Exhibits 9, 11, and 12

Under the section entitled “**IMPORTANT NOTE ABOUT MEDIGAP RIGHTS**” - Added a sentence stating that one does not have to buy Medigap insurance to get coverage under the Original Medicare Plan.

In third bullet "Medigap Open Enrollment" - Deleted phrase regarding Federal law guaranteeing a beneficiary's right to purchase any Medigap policy sold in his/her state.

Rewrote paragraph regarding Federal law.

Exhibit 22 - Model Notice on Failure to Pay Plan Premiums - Added paragraph regarding a member's right to ask for reconsideration regarding changes to the member's plan.

Medicare Managed Care Manual

Chapter 2 - Medicare + Choice Enrollment and Disenrollment

This Chapter Last Updated – Rev. 18, 01-01-03

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NOTE: This chapter replaces policy outlined in OPL 100, OPL 104, OPL 105, OPL 109, OPL 111, OPL 113, OPL 122, and OPL 123.

Exhibit 20 - Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment
Exhibit 21 - Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment
Exhibit 22 - Model Notice on Failure to Pay Plan Premiums - Notice of Reduction in Coverage
Exhibit 23 - Model Notices for Closing Enrollment
Exhibit 24 - Model Notice for Medigap Rights per Special Election Period
Exhibit 25 - Model Notice to Acknowledge Request to Cancel Enrollment
Exhibit 26 - Model Notice to Acknowledge Request to Cancel Disenrollment

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10 - Definitions - (Rev. 18, 01-01-03)

The following definitions relate to topics addressed in this Chapter.

Cancellation of Election - An action initiated by the beneficiary to cancel an election before the effective date of the election.

Completed Election - An election is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative).

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare + Choice Organization (M+CO) (see below for definition of "evidence of Medicare Part A and Part B coverage".)
   There are situations at the end of the month when the M+C organization receives an election form from the beneficiary without any evidence of entitlement to Medicare Part A and Medicare Part B (e.g., copy of a Medicare card, SSA letter). The M+CO is then required to obtain verification of the beneficiary's entitlement through other means. In these cases, CMS will allow for a grace period of ***three business days*** *after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election form was received by the M+CO, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt.*

   For example, if an otherwise complete enrollment form was received on September 30, 2002, the M+C organization has until October 3 to verify Medicare Part A entitlement and Part B enrollment to provide the enrollee with an October 1 effective date.

3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed), and, when applicable;

4. Supporting documentation for a *legal* representative's signature is obtained.

For enrollments, an M+C organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the M+C organization for a prior enrollment before considering an enrollment "complete."

Some States have additional requirements before an enrollment is considered complete. For example, some States require phone verification prior to enrollment. Unless otherwise directed by CMS, M+C organizations should conduct the required activities within the time frames specified by the State. If no time frame is specified, then the M+C organization should complete the required activities as quickly as possible, but within the time frames specified in §40.2.2. The election will not be considered complete until the M+C organization has completed the State-required activities.

Continuation Area/Continuation of Enrollment Option - A continuation area is an additional CMS-approved area outside the M+C plan's service area within which the M+C organization furnishes or arranges for furnishing of services to the M+C plan's continuation of enrollment members. M+C organizations have the option of establishing continuation areas.

Conversions - For individuals who are enrolled in a commercial health plan offered by the M+C organization the month immediately before the month of their entitlement to Medicare Parts A and B, their enrollment in an M+C plan offered by the same organization is referred to as a "conversion" from commercial status to M+C enrollee status. In order for the individual's enrollment with the organization as an M+C enrollee to take effect upon becoming eligible for Medicare, conversions must take place during the individual's Initial Coverage Election Period (ICEP), and the individual must fill out an enrollment form and meet all other applicable eligibility requirements to elect the M+C plan.

Denial of Election - Occurs when an M+C organization determines that an individual is not eligible to make an election (e.g., the individual is not entitled to Medicare Part A or *enrolled in Part* B, the individual has ESRD, the individual is not making the election during an election period, etc.), and therefore decides not to submit the election transaction to CMS.

Election - Enrollment in, or voluntary disenrollment from, an M+C plan or the traditional Medicare fee-for-service program ("Original Medicare") constitutes an election. (Disenrollment from Original Medicare would only occur when an individual enrolls in an M+C plan.) The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, however, then the term is used deliberately, i.e., it is being used to describe only an enrollment, and not a disenrollment. The same applies when the term "disenrollment" is used alone, i.e., the term is being used to describe only a disenrollment, and not an enrollment.

Election Form - The form used by individuals to request to enroll in, or disenroll from, M+C plans. A model individual enrollment form is provided in Exhibit 1. **An individual**

who is a member of an M+C plan and who wishes to elect another M+C plan, even if it is in the same M+C organization, must complete a new election form to enroll in the new M+C plan *(or other CMS approved method, if available.)* *However*, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) or a "selection" form (refer to Exhibit 3a) to make the election in place of the comprehensive individual enrollment form. In addition, M+C organizations may want to collaborate with employer group health plans (EGHPs) to use a single enrollment form *(or other CMS approved method, if available)* for EGHP members; a model EGHP enrollment form for this purpose is provided in Exhibit 2. Beneficiaries or their *legal* authorized representatives must complete enrollment forms to enroll in M+C plans.

Beneficiaries are not required to use a specific form to disenroll from an M+C plan, but if they do not use a form they must submit a signed and written request for disenrollment to the M+C organization. A model disenrollment form is provided in Exhibit 10.

Election Period - The time during which an eligible individual may elect an M+C plan or Original Medicare. The type of election period determines the effective date of M+C coverage. There are several types of election periods, all of which are defined under §30.

Evidence of Medicare Part A and Part B Coverage - For the purposes of completing an enrollment form, the M+C organization must accept any of the following as acceptable evidence of entitlement to Medicare Part A and enrollment in Part B:

1. A Medicare card;
2. A Social Security Administration (SSA) award notice;
3. A Railroad Retirement Board (RRB) letter of verification;
4. A statement from SSA or RRB verifying the individual's entitlement to Medicare Part A and enrollment in Part B;
5. Verification of Medicare Part A and Part B through one of CMS' systems, including CMS data available through CMS subcontractors; or
6. For individuals enrolling in their ICEP, an SSA application for Medicare Part A and B showing the effective date for both Medicare Parts A and B.

NOTE: *CMS will allow for a grace period of three business days after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election form was received by the M+CO, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt.*

Evidence of Permanent Residence - A permanent residence is normally the enrollee's primary residence. An M+C organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify

the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

Institutionalized Individual - An individual who moves into, resides in, or moves out of an institution specified in §30.3.5.

Involuntary Disenrollment - Refers to when an M+C organization, as opposed to the member, initiates disenrollment from the plan. Procedures regarding involuntary disenrollment are found in §§50.2 and 50.3.

Medicare + Choice Organization (M+C organization) - Refer to Chapter 1 (General Administration of the Managed Care/Medicare + Choice Program) for a definition of a*n"* M+C organization."

M+C Organization Error - An error or delay in election processing made under the full control of the M+C organization personnel and one that the organization could have avoided.

Medicare + Choice Plan - Refer to Chapter 1 for a definition of "M+C plan." Elections are made at the M+C **plan level**, not at the **M+C organization level.**

Out-of-Area Members - Members of an M+C plan who live outside the service area and who elected the M+C plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

Receipt of Election - According to 42 CFR 422.60(d), an election has been made when a completed election form has been received by the M+C organization. An election is considered received and must be date stamped by the M+C organization when the M+C organization (or any entity authorized by CMS to process election forms, such as SSA or the RRB) comes into possession of a **completed** election form signed by the enrollee (or as may be the situation in the case of a disenrollment, a written request or other CMS-approved method described in §50.1). A "completed election" form is defined above.

Reinstatement of Election - An action that may be taken by CMS after an individual disenrolls from an M+C plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an M+C plan. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.

Rejection of Election - Occurs when CMS has rejected an election submitted by the M+C organization. The rejection could be due to the M+C organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the M+C plan.

System Error - A "system error" is an unintended error or delay in election processing that is clearly attributable to a specific Federal government system (e.g., the Rail Road Benefit (RRB) system), and is related to Medicare entitlement information or other information required to process an election.

20 - Eligibility for Enrollment in M+C Plans - (Rev. 18, 01-01-03)

In general, an individual is eligible to elect an M+C plan when each of the following requirements are met. More specific detail regarding these requirements is as follows.

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);

2. The individual has not been medically determined to have ESRD prior to completing the enrollment form (see exceptions described under §20.2);

3. The individual permanently resides in the service area of the M+C plan (see exceptions in §20.3 for persons living outside the service area at the time of election);

4. The individual or his/her *legal* representative completes an enrollment form and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 2 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign election forms);

5. The individual is fully informed of and agrees to abide by the rules of the M+C organization that were provided during the election process; and

6. The individual makes the election during an election period, as described in §30.

An M+C organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an M+C plan and continues to be enrolled in his/her employer's or spouse's health benefits plan, then coordination of benefits rules apply.

An M+C eligible individual may not be enrolled in more than one M+C plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described under §60.

20.1 - Entitlement to Medicare Parts A and B - (Rev. 18, 01-01-03)

To be eligible to elect an M+C plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of

the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered" members are outlined in §20.6. Part B only individuals currently enrolled in a *plan created under* §1833 or §1876 of the Social Security Act (the Act) are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an M+C plan.

An M+C organization has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an M+C organization may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an M+C plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the M+C organization. The M+C organization may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the M+C plan.

While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she completes the enrollment form, i.e., the M+C organization may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. However, the organization may consider the enrollment form to be incomplete until it can verify such entitlement or enrollment. Section §40.2.2 provides more information on the steps the organization can take to verify Medicare coverage. In addition, the definition of "Evidence of Part A and Part B Coverage" in §10 lists some of the type of information that can be used to verify coverage.

20.2.1 - Background on ESRD Entitlement - (Rev. 18, 01-01-03)

When an individual files for Medicare based upon ESRD, entitlement can begin:

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis), or
- The first day of the month dialysis began if the individual trains for self-dialysis, or
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before), or
- Prospectively.

The Medicare entitlement date is usually the month an individual receives a transplant or three months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare

entitlement is effective April 1. Therefore, for these individuals, the initial coverage election period (ICEP) would be the time between when dialysis begins and the Medicare entitlement date - the 3-month waiting period for Medicare entitlement.

There are individuals who are approved to perform **self-dialysis**. If an individual is approved for self-dialysis, SSA will waive the 3-month waiting period to begin Medicare entitlement. In cases of self-dialysis, Medicare entitlement is effective the month dialysis begins, rather than the customary 3 months from the month the individual begins dialysis.

EXAMPLE

A Medicare record is established in January for an April 1 entitlement effective date. Since the individual has 3-month waiting period waived, SSA submits a changed record for a January 1 Medicare entitlement effective date.

Medicare pays nothing until *the* individual files for benefits and Medicare coverage becomes effective.

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an **individual in a group health plan**, the group plan is required to be the primary payer for the first 30 months of Medicare eligibility or entitlement (also known as the 30-month coordination of benefits period), as long as the individual chooses to be enrolled in the group health plan. There is nothing to require an individual to file for Medicare immediately upon starting dialysis. The group health plan is primary during the coordination of benefits period, without regard to the number of individuals employed and irrespective of current employment status.

Since an ICEP relates to when an individual becomes entitled to Medicare Part A and B, when possible, the group or M+C organization should coordinate with the individual so that he/she will not be adversely impacted if he/she has the option to elect an M+C plan.

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD - (Rev. 18, 01-01-03)

- Conversions upon ICEP: Individuals who developed ESRD while a member of a health plan offered by an M+C organization and who are converting to Medicare Parts A and B, can elect an M+C plan in the same organization (within the same State, with exceptions) as their health plan during their ICEP. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.) The individuals must meet all other M+C eligibility requirements and must fill out an election form to join the M+C plan.
- Conversions other than ICEP:

1. If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an M+C plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an M+C plan offered by the M+C organization, as long they were in a health plan offered by the same M+C organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3 month period **after** dialysis begins.

   These individuals will be given a special election period. See §30.4.4 for additional instructions.

2. Individuals who are members of a group health plan and are in their 30-month coordination period will have the opportunity to elect an M+C plan at any time during this 30-month period if certain conditions are met. The individual must have been a member of a health plan offered by the M+C organization the month before his/her entitlement to Parts A and B, and must continue to be enrolled in that health plan. The individual must also choose to elect an M+C plan offered by that M+C organization, and must meet all other M+C eligibility requirements.

   These individuals will be given a special election period. See §30.4.4 for additional instructions.

- An individual who elects an M+C plan and who is medically determined to first have ESRD **after** the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), but **before** the effective date of coverage under the plan is still eligible to elect the plan.

- An individual who develops ESRD while enrolled in an M+C plan may continue to be enrolled in the M+C plan.

- Once enrolled in an M+C plan, a person who has ESRD may elect other M+C plans in the same M+C organization (and during allowable election periods, as described under §30.0). However, the member would not be eligible to elect an M+C plan in a different M+C organization or a plan in the same M+C organization in a different State (with exceptions).

- An individual with ESRD whose enrollment in an M+C plan was terminated on or after December 31, 1998 as a result of a contract termination, non-renewal, or service area reduction can make one election into a new M+C plan. The individual must meet all other M+C eligibility requirements, and must enroll during an M+C election period described in section 30, which includes the SEP associated with that specific termination, non-renewal or service area reduction.

Once an individual has exhausted his one election, he*/she* will not be permitted to join another M+C plan, unless his new plan is terminated.

20.3 - Place of Permanent Residence - (Rev. 18, 01-01-03)

An individual is eligible to elect an M+C plan if he/she permanently resides in the service area of the M+C plan. A temporary move into the M+C plan's service area does not enable the individual to elect the M+C plan; the M+C organization must deny such an election.

EXCEPTIONS

- A member who permanently moves from the service area of the M+C plan to an approved continuation area of the M+C organization, and who chooses the continuation of enrollment option offered by the M+C organization, may continue to be enrolled in the M+C plan (refer to §60.7 for more detail on the requirements for the continuation of enrollment option).
- Conversions: Individuals who are enrolled in a commercial health plan of the M+C organization and are converting to Medicare Parts A and B can elect an M+C plan offered by the same M+C organization during their ICEP even if they reside in the M+C organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)
- A member who was enrolled in an M+C plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the M+C plan while living outside the plan's new reduced service area if:
    - There is no other M+C plan serving the area;
    - The M+C organization offers this option; and
    - The member agrees to receive services through providers in the M+C plan's service area.
- The M+C organization has the **option** to also allow individuals who are converting to Medicare Parts A and B to elect the M+C plan during their ICEP even if they reside outside the service **and** continuation area. This option may be offered provided that CMS determines that all applicable M+C access requirements in 42 CFR §422.112 are met for that individual through the M+C plan's established provider network providing services in the M+C plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out-of-area" members. This option applies both to individual members and employer group members of the M+C organization.

Individuals who do not meet the above requirements may not elect the M+C plan. The M+C organization must deny enrollment to these individuals.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but an M+C organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the M+C organization must contact the individual to determine *the* place of permanent residence, unless the person is homeless (see below). If there is a dispute over where the individual permanently resides, the M+C organization should determine whether, according to the law of the M+C organization's State, the person would be considered a resident of that State.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

20.4 - Completion of Enrollment Form - (Rev. 18, 01-01-03)

An eligible individual or authorized individual must fill out an election form to enroll in an M+C plan, **even if that individual is electing an M+C plan in the same M+C organization in which he/she is enrolled**. Unless otherwise specified by CMS, an eligible individual can elect an M+C plan only if he/she completes and signs an enrollment form, provides required information to the M+C organization within required time frames, and submits the properly completed form to the M+C organization for enrollment. Model enrollment forms are included in Exhibits 1, 2, and 3.

An individual who is a member of an M+C plan, and who wishes to elect another M+C plan offered by the same M+C organization, must complete a new enrollment form to enroll in the new M+C plan; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form *or Exhibit 3a for a model selection form*) to make the election in place of the comprehensive individual enrollment form.

An M+C organization must deny enrollment to any individual who does not properly complete the enrollment form within required time frames. Procedures for completing the enrollment form are provided in §40.2 and Appendix 2. Refer to §10 for a definition of "completed election form."

20.5 - Agreeing to Abide By M+C *O*rganization Rules - (Rev. 18, 01-01-03)

An individual is eligible to elect an M+C plan if he/she is fully informed of and agrees to abide by the rules of the M+C organization that were provided during the enrollment

process (refer to §§40.4, 40.4.1, and 40.4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the M+C organization, as described in §40.4. The M+C organization must deny enrollment to any individual who does not agree to abide by the rules of the M+C organization.

20.7 - Eligibility and the Hospice Benefit - (Rev. 18, 01-01-03)

An M+C organization must not deny enrollment to any individual who has elected the hospice benefit. Until the M+C organization acknowledges that it has received the completed enrollment form and gives a coverage effective date to the individual (refer to Exhibit 4, *Exhibit 4a*, and §40), the M+C organization must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

The M+C organization may not disenroll any member solely on the basis of the member electing the hospice benefit either before or after becoming a member of the M+C plan. Instead, the M+C organization must provide, or continue to provide, services unrelated to the terminal condition, including any additional benefits provided for in the M+C plan. If the member chooses to revoke the hospice election, the M+C organization again becomes responsible for providing all covered services and benefits included in the M+C plan. Refer to Chapter 7, "Payments to Medicare + Choice Organizations" for an explanation of special payment provisions for hospice members.

20.8 - Continuation of Enrollment Option - (Rev. 18, 01-01-03)

With CMS approval, an M+C organization may establish continuation areas, separate and apart from an M+C plan's service area. Refer to Chapter 11 (Contracts with Medicare + Choice Organizations) regarding CMS approval of continuation areas. As defined in §10, the CMS-approved continuation area is an additional area outside an M+C plan's service area within which the M+C organization furnishes or arranges for furnishing of services to the M+C plan's members. Members may only choose to continue enrollment with the M+C plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an M+C organization wants to offer a continuation of enrollment option under one or more of the M+C plans it offers, then it must obtain CMS's approval of the continuation area, and the marketing materials that describe the continuation of enrollment option. The M+C organization must also describe the enrollment option(s) in member materials and make the option available to all members of the M+C plan in question who make a permanent move to the continuation area. A*n* M+C organization may require members to give advance notice of their intent to use the continuation of enrollment option. If the M+C organization has this requirement, then it

must fully describe the required notification process in the CMS-approved marketing materials. In addition, the M+C organization must fully explain any continuation option to all potential members of the M+C plan, current members of any other health plan of the M+C organization and current risk and/or M+C members who reside in the M+C plan service area and/or M+C organization continuation area.

If a member does not choose the continuation of enrollment option when he/she is eligible for the option, then the individual is no longer eligible to be a member of the M+C plan, and the M+C organization must initiate the individual's disenrollment. Procedures for continued enrollment are in §60.7 and procedures describing disenrollment for permanent change of residence are described in §50.2.1.

20.9 - Additional Eligibility Requirements for M+C Religious Fraternal Benefit (RFB) Plans - (Rev. 18, 01-01-03)

An M+C RFB plan is a plan that a*n* RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an M+C plan.

30.3.2 - OEP in 2005 - (Rev. 18, 01-01-03)

In 2005, the OEP is from January through June. During this period an individual may make only one OEP election. Once an individual has exercised his/her one OEP election, subsequent elections made during the remaining calendar year (unless made through an ICEP, OEPNEW, OEPI, SEP, or AEP) will be denied or rejected.

After June 30, 200*5*, M+C organizations must deny elections of individuals unless they are eligible for an ICEP, OEPNEW, OEPI, SEP, or AEP. This includes enrollments, disenrollments to another M+C organization, and disenrollments to Original Medicare.

If an M+C organization has a plan that is open for enrollment any time between January and June 200*5*, then it must accept all elections into that plan made during the plan's open enrollment period.

M+C organizations must accept requests for disenrollment from M+C plans during the OEP since Original Medicare is open January through June in 200*5*.

30.5 - Effective Date of Coverage - (Rev. 18, 01-01-03)

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their effective date. Furthermore, except for EGHP elections, the effective date can never be prior to the receipt of a complete election form by the M+C organization. *An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form.* Section 40.2 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

To determine the proper effective date, the M+C organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the completed enrollment form is received by the M+C organization.

Once the election period is identified by the M+C organization, the M+C organization must determine the effective date. Refer to §60.7 to determine the effective date for a continuation of enrollment. In addition, EGHP enrollments may be retroactive. (Refer to §60.6 for more information on EGHP retroactive effective dates.)

Effective dates are as follows:

Election Period	**Effective Date of Coverage**	**Do M+C organizations have to accept elections in this election period?**
Initial Coverage Election Period	First day of the month of entitlement to Medicare Part A and Part B	Yes – unless capacity limit applies
Open Enrollment Period	First day of the month after the month the M+C organization receives a completed enrollment form.	No the M+C organization can choose to be "opened" or "closed" to accept enrollments during this period.
Annual Election Period	January 1 of the following year	Yes – unless capacity limit applies
Special Election Period	Varies, as outlined in §30.4	Yes – unless capacity limit applies

It is possible for an individual to make an enrollment election when more than one election period applies, and therefore it is possible that more than one effective date could be used. Therefore, if an individual makes an enrollment election when more than one

election period applies, an M+C organization must allow the individual to choose the election period (and therefore the effective date) in which he/she is enrolling (see exception in the next paragraph regarding the ICEP).

If the individual's ICEP and another election period overlap, the individual may not choose an effective date any earlier than the month of entitlement to both Medicare Part A and Part B.

EXAMPLE

- If an individual's ICEP is November, December and January (i.e., he will be entitled to Medicare Part A and Part B in February) and an M+C organization receives a completed enrollment form from that individual during the AEP, then the individual may NOT choose a January 1 effective date for the AEP and must be given a February 1 effective date for the ICEP because January 1st is earlier than the month of entitlement to Medicare Part A and Part B.

If an individual makes an enrollment election when more than one election period applies but does not indicate or select an effective date, then the M+C organization should assign an effective date that benefits the individual and should attempt to contact the individual to determine the individual's preference. If unsuccessful, the M+C organization should use the following ranking of election periods (1 = Highest, 4 = Lowest). The election period with the highest rank generally determines the effective date.

Ranking of Election Periods: (1 = Highest, 4 = Lowest)

1. ICEP

2. SEP

3. AEP

4. OEP

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40 - Enrollment Procedures - (Rev. 18, 01-01-03)

An M+C organization must accept elections it receives, regardless of whether they are received in a face-to-face interview, by mail, or by facsimile. M+C organizations must never delay processing of enrollment forms unless the beneficiary's election is being placed on a waiting list, as allowed under §40.5.

An individual must complete and sign an enrollment form, or another CMS accepted form or CMS approved method, to enroll in an M+C plan, **even if that individual in**

electing an M+C plan in the same M+C organization in which he/she is enrolled. If an individual wishes to elect another M+C plan in the same M+C organization, he/she must complete a new enrollment form to enroll in the new M+C plan. However, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form) OR *a* model selection form for changes between M+C plans within an M+CO (Exhibits 3a) to make the election in place of the comprehensive individual enrollment form. With the exception of forms that are faxed to the M+C organization, individuals should submit original, not photocopied, forms.

An M+C organization must send the beneficiary written notice of M+C organization denial of enrollment, CMS confirmation of enrollment, or CMS rejection of enrollment, as described in §§40.2.3 and 40.4.2.

All notice requirements are summarized in Appendix 1.

40.1 - Format of Enrollment Forms - (Rev. 18, 01-01-03)

The M+C organization must use an enrollment form that complies with CMS's guidelines in format and content. A model individual enrollment form is included as Exhibit 1; a model EGHP enrollment form is included as Exhibit 2. *For changes from one plan to another plan within the same M+CO,* a model short form is included as Exhibit 3; and a model *selection* form is included as Exhibit 3a.

The M+C organization's individual and/or EGHP enrollment form must include statements that the member:

- Agrees to abide by the M+C organization's membership rules as outlined in material provided to the member, including the lock-in provisions;
- Authorizes the disclosure and exchange of necessary information with CMS;
- Understands that enrollment in the M+C plan automatically disenrolls him/her from any other M+C, HCPP, or cost plan in which he/she is enrolled;
- Understands that if enrollment forms are submitted for more than one plan with the same effective date, all attempted enrollments may be canceled;
- Knows that the effective date is the date he/she must begin receiving care through the M+C plan; and
- Knows he/she has the right to appeal service and payment denials made by the organization.

The short enrollment form, if used by the M+C organization, must include statements that the member:

- Agrees to abide by the M+C organization's membership rules as outlined in material provided to the member, including the lock-in provisions;
- Authorizes the disclosure and exchange of necessary information with CMS; and
- Knows that the effective date is the date he/she must begin receiving care through the M+C plan.

The model *selection* form for elections from one M+C plan to another within an organization, if used by the organization, must include:

- A description of the M+C plan option's benefits, costs, and premiums;
- Statements that the member understands the lock-in rules that apply under the plan; and
- The signature from the beneficiary or beneficiary's *legal* representative (proof of *legal* authorized representative should be on file).

No enrollment form may include a question regarding whether the individual receives hospice coverage or any other health screening information, with the exception of questions regarding ESRD status and nursing home status.

Refer to §60.8 for requirements regarding retention of enrollment forms.

40.2 - Completing the Enrollment - (Rev. 18, 01-01-03)

If the enrollment form is filled out during a face-to-face interview, the M+C organization should use the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to both Medicare Parts A and B. If the form is mailed or faxed to the M+C organization, the M+C organization should verify this information with the individual via telephone or other means, or request that the individual include a copy of his/her Medicare card when mailing in the enrollment form.

Appendix 2 lists all the elements that must be filled out in order to consider the enrollment form "complete." This list is based on the data elements contained in Exhibits 1, 2, and 3. If the M+C organization receives an enrollment form that contains all these elements, the M+C organization must consider the enrollment form complete even if all other data elements on the enrollment form are not filled out. If an M+C organization has received CMS approval for an enrollment form that contains data elements in addition to those included in Exhibit 1, 2, 3, and 3a, then the election form is considered complete even if those additional elements are incomplete.

If an M+C organization receives an enrollment form that does not have all necessary elements required in order to consider the application complete, it must not deny the enrollment. Instead, the enrollment is considered incomplete and the M+C organization

must follow the procedures outlined in §40.2.2 in order to complete the enrollment. Where possible, the M+C organization should check available systems for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment, the M+C organization could obtain this information via available systems rather than request the information from the beneficiary.

The following should also be considered when completing an enrollment:

- **Permanent Residence Information -** The M+C organization should obtain the individual's permanent residence address to determine that he/she resides within the M+C plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the M+C organization may consider the enrollment form incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the M+C organization should consult the State law in which the M+C organization operates and determine whether the enrollee is considered a resident of the State.

  Refer to §10 for a definition of "evidence of permanent residence," and §20.3 for more information on determining residence for homeless individuals.

- **Entitlement Information -** While desirable, it is not necessary for an individual to prove Medicare Part A entitlement or Part B enrollment **at the time** he/she signs the enrollment form. For example, the M+C organization may not deny the enrollment if the individual does not have the evidence when filling out the enrollment form or does not include it with the form when he/she mails it to the organization. Section 10 contains a list of items that can be considered entitlement evidence under the definition of "evidence of Medicare Part A and Part B coverage."

  *If, at the end of the month, the M+C organization receives an election form from the beneficiary without any evidence of entitlement to Medicare Part A and Medicare Part B (e.g., copy of Medicare card, SSA letter, etc), CMS will allow for a grace period of **3 business days** after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election form was received by the M+CO, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt.*

  For example, if an otherwise complete enrollment form was received on September 30, 2002, the M+C organization has until October 3 to verify Medicare Part A entitlement and Part B enrollment to provide the enrollee with an October 1 effective date

If the individual does not provide evidence of Medicare coverage with the enrollment form and the organization is not able to obtain or verify entitlement through available systems *by the end of the 3-business day "grace period,"* refer to §40.2.2 for additional procedures.

- **Effective Date of Coverage -** The M+C organization must fill out the effective date of coverage block on the enrollment form according to the effective dates outlined in §30.5. If the individual fills out the enrollment form in a face-to-face interview, then the M+C organization representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the M+C organization to confirm the actual effective date. The M+C organization must notify the member of the effective date of coverage prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule), and must write the actual effective date on the enrollment form.

  With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date (effective dates are described in §30.5). Instead, the M+C organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the M+C organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §30.5.

  If a beneficiary mails in an enrollment form with an unallowable prospective effective date, or if the M+C organization allowed the beneficiary to choose an unallowable prospective effective date, the M+C organization must notify the beneficiary in a timely manner and explain that the enrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the notification must be documented. If the beneficiary refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the election according to the procedures outlined in §60.2.1.

- **Health Related Information -** M+C organizations may not ask health screening questions during completion of the enrollment form. With the exception of elections from one M+C plan to another M+C plan in the same M+C organization, in which the M+C organization would already have this type of information, the M+C organization must obtain information on whether the individual has ESRD, is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution. Queries for this information are included on the model individual enrollment form in Exhibit 1, and the model EGHP form in Exhibit 2. Responses to these queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, the responses to these questions must not have an affect on eligibility to enroll in an M+C plan.

- **Statement of Understanding -** As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the M+C plan in order to be eligible to enroll. It is at the M+C organization's discretion to decide whether it will:

    - Have fields next to the statements and require the beneficiary's initials next to each statement (as shown on the last page of Exhibits 1 and 2); or

    - List the statement of understanding and consider the beneficiary signature on the form to signify that the individual has read and understands the statements.

    The M+C organization must apply the policy consistently. If the M+C organization requires the initials and the beneficiary fails to initial his/her understanding of each item listed, the M+C organization may contact the beneficiary to clarify the M+C organization rules in order to complete the enrollment form. The M+C organization must document the contact and annotate the outcome of the contact. If the M+C organization is unable to contact the beneficiary to ensure their understanding, the enrollment form would be considered incomplete.

- **Enrollee Signature and Date -** The individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail). If a legal representative signs the form for the individual, then a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an election on behalf of the applicant must be attached to the form.

    The individual and/or legal representative should also write the date he/she signed the enrollment form; however, if he/she inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the M+C organization places on the enrollment form may serve as the signature date of the form.

- **Other Signatures -** If the M+C organization representative, or any other person, helps the individual fill out the enrollment form, then the M+C organization representative or person must also sign the enrollment form and indicate his/her relationship to the individual. However, the M+C organization representative does not have to co-sign the form when:

    1. He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,

    2. He/she fills in the "office use only" block, and/or

    3. He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The M+C organization representative does have to co-sign the form if he/she pre-fills any other information, including the individual's phone number.

- **Old Signature Dates -** If the M+C organization receives an enrollment form that was signed more than 30 calendar days prior to the M+C organization's receipt of the form, the M+C organization is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

- **Determining the Receipt Date -** The M+C organization must date stamp all enrollment forms as soon as they are initially received at the M+C organization's business offices. If the enrollment form is completed at the time it is date stamped, then the date stamp is equivalent to the "receipt date" (refer to §10 for definitions of "receipt of election" and "completed election"). If the enrollment form is not complete at the time it is date stamped, then the additional documentation required for the enrollment form to be complete must be date stamped as soon as it is received. The date stamp on the last piece of additional documentation received will then serve as the "receipt date." Once the enrollment form is "complete" (based on the definition in §10), then the enrollment form is considered to be "received" by the M+C organization for the purposes of determining the effective date.

- **Final Verification of Information -** Some M+C organizations verify information before enrollment information has been transmitted to CMS. In these cases the M+C organization may find that it must make corrections to an individual's enrollment form. The M+C organization should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the M+C organization (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the M+C organization having to co-sign the enrollment form.

- ***Premiums Owed to the M+CO -*** *An M+C organization may choose to wait for the individual's payment of the plan premium, including any premiums due the M+C organization for a prior enrollment that ended when the beneficiary was disenrolled for nonpayment of basic and supplementary premiums, before considering an enrollment "complete."*

- **Completed Enrollment Forms -** Once the enrollment form is complete, the M+C organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §40.6.

40.2.2 - When The Enrollment Form is Incomplete - (Rev. 18, 01-01-03)

When the enrollment form is incomplete, the M+C organization must document all efforts to obtain additional documentation to complete the enrollment form and have an audit trail to document why the enrollment form needed additional documentation before it could be considered complete. If additional documentation needed to make the application "complete" is not received within 45 days of the request, the organization may deny the enrollment using the procedures outlined in §40.2.3.

Entitlement Information - If the individual has not provided evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment form, the organization may choose to consider an enrollment form complete by obtaining *such* evidence through available systems within seven business days of receipt of the enrollment form.

If the systems indicate that the individual is entitled to Medicare Part A and enrolled in Part B, and the M+C organization has all the other information it needs to complete the enrollment form, then no further documentation from the individual would be needed and the enrollment form is considered complete.

If the systems do not provide evidence of entitlement, then the M+C organization must promptly contact the individual to obtain such evidence.

NOTE: *The CMS will allow for a grace period of 3 business days after the end of the month to obtain such verification. If it is confirmed during the grace period that the beneficiary was entitled to both Medicare Part A and Part B when the election form was received by the M+CO, the date of entitlement will suffice as the evidence and the election form will be considered complete upon receipt*

Requesting Information from the Beneficiary - To obtain information to complete the enrollment form, the M+C organization must contact the individual to request the information (see Exhibit 5 for a model letter). If the contact is made orally, the M+C organization must document the contact and retain the documentation in its records. The M+C organization must explain to the individual that the individual has 30 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete election form is an invalid enrollment (as explained in §40.6), if the additional documentation is not received within 45 calendar days of request (i.e., after allowing for the 30 days plus an additional 15 days for information to be received and logged in by the M+C organization), the M+C organization must send a denial of enrollment letter (see Exhibit 7 for a model denial of enrollment letter).

If all documentation is received within allowable time frames and the enrollment form is complete, the M+C organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4.

40.4.1 - Prior to the Effective Date of Coverage - (Rev. 18, 01-01-03)

Prior to the effective date of coverage the M+C organization must provide the member with all the necessary information about being a Medicare member of the M+C organization, the M+C organization rules, and the member's rights and responsibilities. (An exception to this requirement is described in §40.4.2.) The M+C organization must also provide the following to the individual:

- A copy of the completed enrollment form, if the individual does not already have a copy of the form;
- A letter acknowledging receipt of the completed enrollment form (refer to Exhibit 4 and *Exhibit 4a* for a model letter) and showing the effective date of coverage; and
- Evidence of health insurance coverage so that he/she may begin using plan services as of the effective date

  NOTE: This is not the same as the Evidence of Coverage document described in Chapter 3 - Marketing.

  This evidence may be in the form of member cards, the enrollment form, and/or a letter to the member (refer to Exhibit 4 and *Exhibit 4a*, which is a model letter with optional language that would allow the member to use the letter as evidence of health insurance coverage until he/she receives a member card).

  NOTE: If the M+C organization does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

Regardless of whether an election is made in a face-to-face interview, by fax, or by mail, the M+C organization must explain:

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance.
- The prospective member's authorization for the disclosure and exchange of necessary information between the M+C organization and CMS.
- The lock-in requirement. The M+C organization must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care.

- The potential for member liability if it is found that the member is not entitled to Medicare Part A and Part B at the time coverage begins and the member has used M+C plan services after the effective date.
- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the M+C organization has not yet provided the ID cards).

40.4.2 - After the Effective Date of Coverage - (Rev. 18, 01-01-03)

The CMS recognizes that for some election periods, the M+C organization will be unable to mail the materials and notification of the effective date to the individual prior to the effective date, as required in §40.4.1. These cases will only occur in the last few days of an *election period*, when a completed enrollment form is received by the M+C organization, and the effective date is the first of the upcoming month. In these cases, the M+C organization should mail the member all materials described above no later than 7 business days after receipt of the completed enrollment form. In these cases, the M+C organization is also strongly encouraged to call the member within 1 business day after the effective date to provide the effective date and explain the M+C organization rules.

Acceptance/Rejection of Enrollment - Once the M+C organization receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the M+C organization should notify the individual in writing of CMS's acceptance or rejection of his/her enrollment within seven business days of the availability of the reply listing (see *Exhibits 6*, *Exhibit 6a*, and *Exhibit 8* for model letters).

The one exception is if the organization receives the initial CMS reply listing that rejects the individual's enrollment due to no Medicare Part A and/or no Medicare Part B. In this case, the M+C organization should request a retroactive enrollment from the RO within 45 days from the availability of the initial reply listing. If the RO is unable to process the retroactive enrollment due to its determination that the individual does not have Medicare Part A and/or Part B, the M+C organization must reject the enrollment and should notify the individual of the rejection in writing within seven business days after the RO determination. Retroactive enrollments are covered in more detail in §60.4.

If an M+C organization rejects an enrollment and later receives additional information from the individual showing entitlement to Medicare Part A and enrollment in Part B, the M+C organization must obtain a new enrollment form from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §60.4 for more information regarding retroactive enrollments and the 45-day requirement.

40.5.1 - Procedures After Reaching Capacity - (Rev. 18, 01-01-03)

If the number of individuals who elect to enroll in an M+C plan exceeds a CMS-approved capacity limit, then the M+C organization may limit enrollment of these individuals, but only if it provides priority in acceptance.

If an M+C organization receives completed enrollment forms between the time it reaches its limit and the time CMS approves the limit, it may follow one of two options **after it receives approval from CMS to limit enrollment:** (1) Deny the enrollment due to the onset of the capacity limit, or (2) Place the enrollment on a waiting list to be processed as vacancies occur in the priority of acceptance. This priority requires that the M+C organization process enrollments from individuals who elected the M+C plan prior to CMS's determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment form, and in a manner that does not discriminate on the basis of any factor related to health as described in 42 CFR §422.110.

The M+C organization must take the same action for all enrollment forms received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the M+C organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The M+C organization may follow one of two options: (1) Deny the enrollment due to the capacity limit, or (2) Place the enrollment on a waiting list to be processed when the plan re-opens for enrollment. However, to ensure no discrimination is applied to applications processed, all M+C organizations that use option 1 (i.e., deny enrollment) for enrollments discussed in the above paragraph, must continue to deny all enrollments received while the plan is closed for enrollment, and may not use option 2. The M+C organization must take the same action for all enrollment forms received. In the case of enrollments received after the plan closes for enrollment, the date the M+C plan re-opens becomes the "receipt date" of enrollment forms received when the plan was closed.

EXAMPLE

If the plan was closed in April and re-opens on May 1, then the receipt date of enrollment forms received in April is May 1. See below for procedures for following options 1 or 2.

If the M+C *O*rganization Uses Option 1 - It must notify the individual in writing that it is denying the enrollment, and should do so within seven business days after it receives the enrollment form or after the M+C organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages M+C organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another M+C plan while waiting for the original M+C plan to re-open.

If the M+C *O*rganization Uses Option 2 - It must notify the individual in writing that he/she has been placed on a waiting list, and should do so within seven business days after the M+C organization receives the enrollment form or after the M+C organization receives approval from CMS to limit enrollment. The notice must also provide an estimated length of time that the individual will be on a waiting list and instruct the individual that he may cancel his enrollment before a vacancy occurs.

As enrollment spaces become available, if the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the M+C organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The M+C organization may make this contact even if the plan was closed for less than 30 days.) Within seven business days after contacting the individual, the M+C organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the M+C plan.

For individuals who indicate their continued interest in enrollment, the M+C organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc.

There may be situations in which the M+C organization has closed enrollment in a service area, yet receives an approval for a capacity limit for a portion of that same service area. Given that M+C plans are either open or closed for an ENTIRE service area, any vacancies which may open up may only be filled by individuals in their ICEP or SEP by applying the rules of accepting enrollments when M+C plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

50.1 - Voluntary Disenrollment by Member - (Rev. 18, 01-01-03)

A member may only disenroll from an M+C plan during one of the election periods outlined in §§30 and 30.7. The member may disenroll by:

1. Giving or faxing a signed written notice to the M+C organization;
2. Submitting a request via Internet to the M+C organization (if the M+C organization offers such an option);
3. Giving a signed written notice to any SSA or RRB office (refer to *§50.8* for procedures for Medicare MSA plans); or
4. By calling 1-800-MEDICAR(E).

If a member verbally requests disenrollment from the M+C plan, as mentioned in #1 and #2 above, the M+C organization must instruct the member to make the request in writing.

The M+C organization may send a disenrollment form to the member upon request (see Exhibits 9 and 10).

The disenrollment request must be date stamped when it is initially received at the M+C organization's business offices.

Requests Submitted via Internet

The M+C organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The M+C organization must, at a minimum, comply with the CMS security policies - found at http://cms.hhs.gov/it/security/. However, the M+CO may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies also require M+C organizations to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the M+C organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the M+C organization to ascertain whether it is in compliance with the security policy. The effective date of the request is received by the specified site designated by the M+C organization.

Request Signature and Date

When providing a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §40.2.1 for more detail on who may sign election forms). If a legal representative signs the request for the individual, then a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law must be attached to the request.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the stamped date of receipt that the M+C organization places on the request form may serve as the signature date.

Effective Dates

The election period will determine the effective date of the disenrollment; refer to §§30.6 and 30.7 for information regarding disenrollment effective dates.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date. Instead, the M+C organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the M+C organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §§30.6 and 30.7.

If a beneficiary mails in a disenrollment request with an unallowable prospective effective date, or if the M+C organization allowed the beneficiary to choose an unallowable prospective effective date, the M+C organization must call or write the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the call must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary can cancel the election according to the procedures outlined in §60.2.2.

Notice Requirements

After the member submits a request, the M+C organization must provide the member a copy of the request for disenrollment and a disenrollment letter, and should do so within seven business days of receipt of the request to disenroll. The disenrollment letter must include an explanation of the lock-in restrictions for the period during which the member remains enrolled in the organization, and the effective date of the disenrollment (see Exhibit 11). The M+C organization may also advise the disenrolling member to hold Original Medicare claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the plan. For these types of disenrollments, i.e., disenrollments in which the member has disenrolled directly through the M+C organization, M+C organizations are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the reply listing.

Since Medicare beneficiaries have the option of disenrolling through SSA, RRB, 1-800-MEDICAR(E), or by enrolling in another Medicare managed care plan, the M+C organization will not always receive written request for disenrollment from the member and will instead learn of the disenrollment through the CMS Reply Listing Report. If the M+C organization learns of the voluntary disenrollment from the CMS reply listing (as opposed to through written request from the member), the M+C organization must send written confirmation of the disenrollment to the member, and should do so within seven business days of the availability of the reply listing (see Exhibit 12).

Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

M+C organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The M+C organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2.1 - Members Who Change Residence - (Rev. 18, 01-01-03)

General Rule

The M+C organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;

2. He/she permanently moves out of the continuation area and his/her new residence is not in the service area or another continuation area;

3. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members) and into a continuation area, but chooses not to continue enrollment in the M+C plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);

4. The member is an out-of-area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;

5. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds six consecutive months. The M+C organization may not disenroll members whose absence from the service area (or continuation area, for continuation of enrollment members) lasts for six months or less; or

6. The member is an out-of-area member (as defined in §10), who leaves his/her residence for more than six months.

Generally disenrollments for reasons 1 - 4 above are effective the first day of the calendar month after the date the member begins residing outside of the M+C plan's service area (or continuation area, as appropriate) and after the M+C organization has been notified by the member or his/her *legal* representative. Disenrollment for reasons 5 and 6 above is effective the first day of the calendar month after six months have passed.

M+C organizations may consider the six months to have begun on the date given by the beneficiary as the date that he/she will be leaving the service area. If the beneficiary did not inform the M+C organization of when he/she left the service area, then the M+C organization can consider the six months to have begun on the date the change in address is identified (e.g. through the reply listing report).

NOTE: CMS is currently in the process of developing a notice of proposed rulemaking in which we expect to address the issue of "extended enrollment" or visitor/traveler programs. Directions on this matter will be available in a subsequent update to this chapter. M+C organizations that offer a visitor/traveler benefit allowing out of area enrollment for up to 12 months at this time should contact their plan manager for further guidance.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change of election to Original Medicare.

A SEP, as defined in §30.4.1, applies to members who are disenrolled due to a change in residence. A member may choose another M+C plan, or Original Medicare, during this SEP. The rules for this SEP will determine the effective date in the new M+C plan or Original Medicare.

Researching and Acting on a Change of Address

M+C organizations may receive a notice of a change of address from the member, the member's *legal* representative, a CMS reply listing, or another source. M+C organizations may require members to provide written verification of changes in address, but they may also choose to allow verbal verification, as long as the M+C organization applies the policy consistently among all members.

If the M+C organization receives notice of a permanent change in address from the member or the member's *legal* representative, and that address is outside the M+C plan's service area (or continuation area, for continuation of enrollment members), then the M+C organization must disenroll the member and provide proper notification. The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.7). If the change in address is temporary (i.e., not expected to exceed six months), then the M+C organization may not initiate disenrollment. The M+C organization must retain documentation from the member or member's *legal* representative of the notice of the change in address.

If the M+C organization receives notice of a new address from a source other than the member or the member's *legal* representative, and that address is outside the M+C plan's service area (or continuation area, for continuation of enrollment members), then the M+C organization may not assume the move is permanent until it has received

confirmation from the member or member's *legal* representative. The CMS suggests that the M+C organization contact the member directly or in writing to verify address information in order to determine whether disenrollment is appropriate. The M+C organization must give the member at least 20 calendar days to respond to the verification request. The M+C organization must retain documentation from the member or member's *legal* representative of the notice of the change in address, including the determination of whether the move is temporary or permanent.

- If, based on this verification, the M+C organization determines a member's move is permanent, then the M+C organization must disenroll the member and provide written notice of disenrollment to the member. The only exception is if the member has moved into and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.7).
- If the M+C organization determines the change in address is temporary, then the M+C organization may not initiate disenrollment until six months have passed from the date the M+C organization learned of the change in address (or from the date the member states that his address changed, if that date is earlier).
- If the member does not respond to the request for verification within the time frame given by the M+C organization, then the M+C organization must assume the move is not permanent and may not disenroll the member. The M+C organization may continue its attempts to verify address information with the member, but may not initiate disenrollment unless it verifies a move is permanent or until the member has been out of the service area (or continuation area, for continuation of enrollment members) for over six months from the date the M+C organization learned of the change in address.

Notice Requirements

The M+C organization is strongly encouraged to contact a member directly or in writing when it learns of a change of address from a source other than the member or the member's *legal* representative, in order to verify the change of address and determine whether disenrollment is necessary. The M+C organization must give the member at least 20 calendar days to respond to the request for verification.

The M+C organization must provide written notification of disenrollment to the member upon the M+C organization's learning through the member or a member's *legal* representative of the permanent move. This notice must be sent within seven business days of the M+C organization's learning of the permanent move before the disenrollment transaction is submitted to CMS.

In the notice, the M+C organization is encouraged to inform the member who moves out of the service area that he/she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the M+C

organization ends. The M+C organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

If the member has left the service area (without having chosen a continuation area) or continuation area (for continuation of enrollment members) for six months after the date the M+C organization learned of the change in address (or the date the member stated that his address changed, if that date is earlier), the M+C organization must provide written notification of the upcoming disenrollment to the member. This written notice must also be sent to out-of-area members (as defined in §10) who leave their residence for a location outside the service area, and that absence exceeds six months. The notice must be sent some time during the sixth month, or no later than seven business days after the sixth month as long as the notice is sent before the disenrollment transaction is submitted to CMS. The notice must advise the member to notify the M+C organization within 20 calendar days of the date of the notice if the information is incorrect. The notice must also state that if the member has not responded after the 20 days have passed, or if the member indicates that he/she will not be returning to the service/continuation area before the six months have passed, the M+C organization must disenroll the member effective with the first day of the month following the 20-day notice. The CMS strongly encourages that M+C organizations send final confirmation of disenrollment to the member to ensure the individual does not continue to use M+C organization services.

50.3.2 - Disruptive Behavior - (Rev. 18, 01-01-03)

The M+C organization **may** disenroll a member if the member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his/her continued enrollment in the plan seriously impairs the M+C organization's ability to furnish services to either the particular member or other members enrolled in the plan. However, the M+C organization may only disenroll a member for disruptive behavior upon approval from CMS. The M+C organization may not disenroll a member because the member exercises the option to make treatment decisions with which the M+C organization disagrees, including the option of no treatment and/or no diagnostic testing. The M+C organization may not disenroll a member who chooses not to comply with any treatment regimen developed by the M+C organization or any health care professionals associated with the M+C organization.

Before beginning the disenrollment for cause process, the M+C organization must make a serious effort to resolve the problems presented by the member. This includes making an effort to provide reasonable accommodations for individuals with disabilities, in accordance with the Americans with Disabilities Act. It must inform the member, in writing, that his/her continued behavior may result in termination of membership in the plan. Such efforts must include the use (or attempted use) of the organization's grievance procedures. In this process, the member has a right to submit any information or explanation that he/she may wish to the M+C organization.

If the problem cannot be resolved, the M+C organization must give the member written notice of the M+C organization's intent to request, from CMS, permission to disenroll for cause.

The M+C organization must establish that the member's behavior is not related to the use, or lack of use, of medical services or to diminished mental capacity. The organization must document the member's behavior, the efforts it has taken to resolve any problems, and any extenuating circumstances cited under 42 CFR 422.74(d)(2)(iii) and (iv). In addition to a summary of the case and a reason for the disenrollment request, the M+C organization must submit to the CMS *Regional Office* a description of the member's age, diagnosis, mental status, functional status, and social support systems, as well as statements from primary providers describing their experiences with the member. After a review of this documentation, the CMS *Regional Office* will decide whether the organization may disenroll the member on this basis. Such review will include any documentation or information provided either by the organization or the member (information provided by the member must be forwarded by the organization to the CMS RO), and CMS will make the decision within 20 calendar days after receipt of this information. The M+C organization will be notified within seven business days after CMS's decision. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment. Any disenrollment processed under these provisions will always result in a change of election to Original Medicare.

Notice Requirements

The M+C organization must inform the member, in writing, that his/her continued behavior may result in termination of membership in the plan. If the problem cannot be resolved, the M+C organization must give the member written notice of the M+C organization's intent to request disenrollment for cause. This notice must include an explanation of the organization's grievance procedures. In this process, the member has a right to submit any information or explanation that he/she may wish to the organization. Refer to Chapter 13 (Grievances, Organizations Determinations, and Appeals) for the appropriate procedures for grievances.

If CMS permits an M+C organization to disenroll a member for disruptive behavior, the M+C organization must provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. While there is no required timeframe in which the M+C organization must provide notice to the member, the M+C organization may provide the member the required notice as soon as CMS notifies the M+C organization of the approved disenrollment. The M+C organization can only submit the transaction to CMS after it has provided the notice of disenrollment to the individual. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment.

50.5 - Disenrollments Not Legally Valid - (Rev. 18, 01-01-03)

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §50.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in §10, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

The CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her *legal* representative did not intend to disenroll from the M+C organization. If there is evidence that the member did not intend to disenroll from the M+C organization, the M+C organization should submit a reinstatement request to the CMS RO. Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or
- Request by the member for cancellation of disenrollment before the effective date (refer to §60.2 for procedures for processing cancellations).

Discontinuation of payment of premiums does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g., filing a Form CMS-566 with SSA, sending a written request for disenrollment to the M+C organization, or calling 1-800-MEDICAR(E)) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

60.2.1 - Cancellation of Enrollment - (Rev. 18, 01-01-03)

An individual's enrollment can only be cancelled if the request is made prior to the effective date of the enrollment.

To ensure the cancellation is honored, the M+C organization should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment

by the time it receives the request for cancellation, *it may attempt to submit a corresponding disenrollment transaction to CMS to "cancel out" the now void enrollment transaction. In the event the M+C organization has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, or has other difficulty, the M+C organization* should contact the CMS RO in order to cancel the enrollment.

When canceling an enrollment the M+C organization must send a letter to the individual that states that the cancellation is being processed (see Exhibit 25). This notice should be sent within seven business days of the request. The language in the notice will depend upon whether the organization has already sent the enrollment transaction to CMS.

- If the enrollment transaction was not sent to CMS, then the notice must inform the member that the cancellation will result in the individual remaining enrolled in the health plan he/she originally was enrolled in.
- If the enrollment transaction was sent to CMS (in which the RO has been contacted to cancel the enrollment), then the notice must inform the member that if he/she was already enrolled in another M+C plan, then the current enrollment action will have caused him/her to be disenrolled from the health plan he/she originally was enrolled in. The notice must also instruct the individual to contact the original M+C organization if he/she wishes to remain a member of the M+C plan in that M+C organization.

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation cannot be processed. The M+C organization must inform the member that he/she is a member of its M+C plan. If he/she wants to get back into the other M+C plan he/she will have to fill out an enrollment form to enroll in that M+C plan during an election period, and with a current effective date.

If the member wants to return to Original Medicare, the member must be instructed to disenroll from the plan in writing with the M+C organization, SSA, or the RRB, or to call 1-800-MEDICAR(E). The member must be informed that the disenrollment must be made during an election period (described in §30.5) and will have a current effective date (as prescribed in §30.5), and must be instructed to continue to use plan services until the disenrollment goes into effect.

60.2.2 - Cancellation of Disenrollment - (Rev. 18, 01-01-03)

A member's disenrollment can only be canceled if the request is made prior to the effective date of the disenrollment.

To ensure the cancellation is honored, the M+C organization should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, *it may attempt to submit a corresponding enrollment transaction to CMS to "cancel out" the now void*

disenrollment transaction. In the event the M+C organization has submitted the disenrollment and is unable to submit the "canceling" enrollment transaction, or has other difficulty, the M+C organization should contact the CMS RO in order to cancel the disenrollment.

The M+C organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using M+C plan services (see Exhibit 26). This notice should be sent within seven business days of the request.

If the member's request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §60.3.2. If a reinstatement will not be allowed, the M+C organization should instruct the member to fill out and sign a new enrollment form to re-enroll with the M+C organization during an election period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member - (Rev. 18, 01-01-03)

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made> for those members who are able to cancel the disenrollment before the effective date of the disenrollment (as outlined in §60.2.2), given that this type of cancellation generally results in no changes to CMS records.

Reinstatements will be allowed at the request of a member who enrolled in a second M+C organization, which resulted in an erroneous disenrollment from the original M+C organization in which he/she was enrolled, and who was able to cancel the enrollment in the second M+C organization (as outlined in §60.2.1). When a cancellation of enrollment in a second M+C organization is properly made, the associated automatic disenrollment from the first M+C organization becomes invalid. Generally, these reinstatements will only be granted when the member submits the request for reinstatement in writing in the time frames described in the next paragraph, and has only used health care services from providers in the original (first)M+C plan (not including emergency or urgently needed services) since the original effective date of the disenrollment.

In these cases, when a disenrolled member verbally contacts the original M+C organization to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the M+C plan, *the* M+C organization must instruct the member to notify the M+C organization in writing of the desire to remain enrolled in the plan within 30 calendar days after the M+C organization sent the notice of disenrollment to the individual (i.e., the notices shown in Exhibit 12). Regardless of whether the request for

reinstatement is verbal or in writing, the M+C organization must also instruct the member as soon as possible to continue to use M+C plan services (refer to Exhibit 17 for a model letter).

If the M+C organization does not receive the written statement requested from the member within the required time frame, then it must close out the reinstatement request by notifying the individual of the denial of reinstatement (refer to Exhibit 18 for a model letter), and should do so within seven business days after the date the member's written request was due at the M+C organization.

To request reinstatement from the CMS RO, the M+C organization must submit the following information to its RO:

- A copy of the reply listing showing the disenrollment (include the system run date);
- A copy of the disenrollment letter sent to the individual. Refer to model letter in Exhibit 12 (or Exhibit 11, if appropriate);
- A copy of any correspondence from the member disputing the disenrollment and indicating that he/she wants to remain enrolled in the plan. Member correspondence could include a summary of the facts, phone contact reports, and copies of letters;
- A copy of the letter to the member informing him/her to continue to use M+C plan services until the issue is resolved and instructing him/her to state the intent to continue enrollment in writing. Refer to model letter in Exhibit 17; and
- A copy of the written statement from the member indicating he/she wants to remain enrolled in the M+C plan and has not used non-plan services (except for emergency or urgently needed services).

60.4 - Retroactive Enrollments - (Rev. 18, 01-01-03)

The CMS ROs will only process requests for retroactive enrollments when the M+C organization has notified the member that he/she must use M+C plan services during the period covered by the retroactive enrollment request. Retroactive enrollments will be approved by the CMS RO when an individual has fulfilled all election and eligibility requirements for an M+C plan, but the M+C organization or CMS is unable to process the election for the statutorily required effective date (as outlined in §30.5).

Unlike a reinstatement, which is a correction of records to "erase" an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period. Therefore, retroactive enrollments may NOT be made back to a date when an M+C plan was closed for enrollment.

NOTE: Keep in mind that unless a capacity limit applies, all M+C plans are open for ICEP, AEP, and SEP elections; therefore, all M+C plans are open for retroactive enrollments for these type of elections.

The following documentation must be submitted to the RO for all retroactive enrollment requests. The retroactive enrollment request should be made within 45 calendar days of the availability of the first reply listing.

1. Copy of signed completed enrollment form.

   NOTE: The form must have been signed by the applicant prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage.

2. Copy of M+C organization's letter to the member acknowledging receipt of the completed enrollment form and notifying the member to begin using the M+C plan's services as of the effective date (refer to Exhibit 4 or *Exhibit 4a* for the model letter). The letter must be dated prior to the requested retroactive effective date of coverage (or, when appropriate as outlined in §40.4.2, within seven business days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

3. One or more of the examples of "evidence of Medicare Part A and Part B coverage" cited in §10.

4. For cases of *an* erroneous indicator of no Medicare entitlement - Copies of two reply listings, including a copy of the system run date, indicating the M+C organization's attempts to correctly enroll the individual and the resulting rejections. One reply listing will be considered acceptable if the M+C organization would be unable to obtain a second reply listing and still submit the retroactive enrollment request within 45 calendar days of the availability of the first reply listing; however, two reply listings are preferred. The M+C organization may submit the McCoy exception report in place of the reply listing. The effective date on the first reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date of coverage.

5. For cases of *an* erroneous indicator of ESRD, either because the individual has never had ESRD or because ESRD status has been terminated:

   A. Evidence of contact with the individual after the first systems rejection, including the individual's explanation for rejection. If the individual reports that he/she no longer has ESRD or that he/she has had a kidney transplant or no longer receives dialysis services, then provide medical documentation, for example a letter from the physician or dialysis facility that documents date of transplant or last month of dialysis. If the individual reports that he/she never had ESRD, provide a statement signed by the individual (or his/her physician) to that effect.

B. A copy of the reply listings or print screens indicating the M+C organization's attempts to correctly enroll the individual and the resulting rejection. The effective date on the reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date.

In the event that CMS determines that the M+C organization did not notify the member that he/she must use M+C plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request will be denied. In this case, if the Medicare eligible individual has used M+C plan services during the period covering the retroactive enrollment request, the M+C organization may bill Medicare for the services. The M+C organization may bill for Medicare Part B services from the Medicare carrier.

NOTE: The M+C organization must have an indirect billing number from CMS.

Or, the M+C organization may have its certified M+C plan providers bill for Medicare Part B services. The certified M+C plan providers may bill the Medicare fiscal intermediary for Medicare Part A services. M+C organizations may not bill for Medicare Part A services. The beneficiary would remain responsible for any co-insurance and deductible.

If an M+C organization is making a retroactive request that is a result of M+C organization error or system problems (as defined in §10) in which the enrollment is not recorded on a timely basis by the M+C organization or in CMS records, the M+C organization must submit the request to:

- The CMS central office, for a CMS or SSA computer system problem involving multiple members, or
- The CMS RO, for individual cases or situations when the organization is experiencing internal problems.

If the CMS RO is not able to resolve system errors, the recommendation is submitted to CMS central office for correction.

60.6.1 - EGHP Retroactive Enrollments - (Rev. 18, 01-01-03)

The CMS will allow the M+C organization to submit the EGHP enrollment to CMS with retroactive enrollment dates. However, the effective date cannot be prior to the signature date on the election form. The effective date may be adjusted to reflect a retroactive adjustment in payment of up to, but not exceeding, 90 days **payment** adjustment, to conform with the adjustments in payment described under §422.250(b).

EXAMPLE

In March 2002, the CMS system processing date was March 13, 2002. Elections processed by CMS for the March 13, 2002 due date were for the prospective April 1, 2002, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30-, 60-, and 90-days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP election were to be received on *March 5, 2002*, the retroactive effective date could be January 1, February 1, or March 1.

NOTE: Keep in mind that unless a capacity limit applies, all M+C plans are open for ICEP, AEP, and SEP elections. Therefore, all M+C plans are open for retroactive enrollments for these type of elections

No retroactive enrollments may be made unless the individual certifies that the M+C organization (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The M+C organization should submit such enrollments using a number 60 enrollment code. Refer to Chapter 19, "Managed Care and M+C Systems Requirements", and the Enrollment and Payment User's Guide for more detail on the use of code 60.

Medicare Managed Care Manual

Chapter 2 - Medicare + Choice Enrollment and Disenrollment

Appendices and Exhibits

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Appendix 1: Summary of Notice Requirements (3 Pages) - (Rev. 18, 01-01-03)

Referenced in sections: 10, 30, 40, 50 and 60

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this Chapter.

Notice	Section	Required?	Timeframe
Individual Enrollment Form (Exh. 1)	10, 40.1, 40.2, 40.4.1	Yes	NA
EGHP Enrollment Form (Exh. 2)	10, 40.1, 40.2, 40.4.1	No	NA
Short Enrollment Forms (Exh. 3 and 3a)	10, 40.1, 40.2, 40.4.1	No	NA
Acknowledgment of Receipt of Completed Enrollment Form (Exh. 4 *and 4a*)	40.4.1, 60.4	Yes	Before effective date, or if late in election period, 7 business days of receipt of completed enrollment form
Request for Information (Exh. 5)	40.2.2	No	NA
Confirmation of Enrollment (Exh. 6 and 6a)	40.4.2, 40.6	Yes	7 business days of reply listing
M+CO Denial of Enrollment (Exh. 7)	40.2.3	Yes	7 business days of denial determination

Notice	Section	Required?	Timeframe
			determination
CMS Rejection of Enrollment (Exh. 8)	40.4.2	Yes	7 business days of reply listing (one exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9-10)	50.1	No	NA
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	50.1, 50.4.1	Yes	7 business days of receipt of written request to disenroll
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA
Confirmation of Voluntary Disenrollment Identified Through Reply Listing (Exh. 12)	50.1, 50.4.1. 60.3.2	Yes	7 business days of reply listing
Verification of Change in Address (no exhibit)	50.2.1	No	NA
Disenrollment Due to Permanent Move (no exhibit)	50.2.1	Yes	Within 7 business days of learning of the permanent move and no later than before the disenrollment transaction is submitted to CMS
Notice of Upcoming Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	Yes	Any time during the 6th month, or no later than 7 business days after the 6th month as long as the notice is sent before the disenrollment transaction is submitted to CMS
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	No	NA
Disenrollment Due to Death (Exh. 13)	50.2.3, 50.4.2, 60.3.1	No	NA
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 50.4.2, 60.3.1	No	NA

Notice	Section	Required?	Timeframe
Notices on Terminations/Nonrenewals	50.2.4	Yes	Follow requirements in 42 CFR §§422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	NA
Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before the disenrollment transaction is submitted to CMS
Disenrollment for Fraud and Abuse (no exhibit)	50.3.3	Yes	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.3, 60.3.1	Yes	7 business days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	60.3, 60.3.1	Yes	7 business days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another M+C organization (Exh. 17)	60.3, 60.3.2	Yes	7 business days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	60.3.2	Yes	7 business days after information was due to M+C organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 20 days after delinquent premiums due
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	50.3.1	Yes	Before the disenrollment transaction is submitted to CMS
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	50.3.1	No	NA

Notice	Section	Required?	Timeframe
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	50.3.1	Yes	Prior to effective date of reduction in coverage
Public Notices For Closing Enrollment (Exh. 23)	40.5	Yes	30 calendar days before closure (15 days if related to CMS approved capacity limit)
Notice that Election Placed on Waiting List *(no exhibit)*	40.5.1, 40.5.2	Yes	7 business days of receiving enrollment form or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll *(no exhibit)*	40.5.1, 40.5.2	No	NA
Intent to Not Process Enrollment *(no exhibit)*	40.5.1, 40.5.2	Yes	7 business days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	50.2, 50.1	No	Upon request.
Request to cancel enrollment (Exh. 25)	60.2.1	Yes	7 business days of request
Request to cancel disenrollment (Exh. 26)	60.2.2	Yes	7 business days of request

Appendix 2: Data Elements Required to Complete the Enrollment Form (2 Pages) - (Rev. 18, 01-01-03)

Referenced in section(s): 20, 20.4, 40.2

All data elements with a “Yes” in the “Required before enrollment complete” column are necessary in order for the enrollment to be considered complete.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
1	M+C Plan name	Yes	1, 2, 3, 3a
2	Effective date of coverage	No[1]	1, 2, 3, 3a
3	Beneficiary name	Yes	1, 2, 3, 3a
4	Beneficiary Medicare number	Yes	1, 2, 3
5	Beneficiary Date of Birth	Yes	1, 2
6	Beneficiary Sex	Yes	1, 2
7	Permanent Residence Address	Yes	1, 2, 3
8	Mailing Address	No	1, 2, 3
9	Beneficiary Telephone Number	No	1, 2, 3
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	1, 2
11	Language preferences (Optional Field)	No	1, 2
12	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	2
13	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	2

[1] While it is true the effective date must be established in order to complete the election, it is not the beneficiary who fills out this data element. As indicated in section 40.2, the effective date of coverage is filled in by the M+C organization. Therefore, the "no" in this column is simply intended to mean that the beneficiary does not have to fill in this data element in order to complete the election.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
14	Medicare information contained on sample Medicare card, or copy of card	No[2]	1, 2
15	M+C Plan/Product choice	Yes	1, 2, 3a
16	M+C Product/Premium Choice	Yes	3
17	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	2
18	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	1, 2, 3
19	Beneficiary signature and/or Beneficiary Representative Signature	Yes	1, 2, 3,3a
20	Signature and Relationship of any individual who helped beneficiary fill out form (if applicable)	Yes	1, 2, 3, 3a
21	Date of signatures	No[3]	1, 2, 3, 3a
22	Response to question 1 on page 3 ("Please read and answer these questions")	Yes	1, 2
23	Response to questions 2 - 5 on page 3 ("Please read and answer these questions")	No	1, 2
24	Initials/annotation next to all statements on page 4 ("Please read these sentences and put your initials next to them")	M+CO decision[4]	1, 2

[2] As stated in section 40.2, an M+C organization may not refuse to accept an enrollment form when an individual does not have his/her Medicare card available at the time s/he fills out an enrollment form; however, the enrollment form will not be considered complete until the M+C organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the M+C organization needs, at a minimum, the Medicare number in order to verify entitlement to Part A and enrollment in Part B; we have accounted for the need for this data element under data element number 4.

[3] As explained in section 40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the M+C organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
25	Employer Name and Group Number	Yes	2
26	Question of which M+C plan/premium the beneficiary is currently a member of and to which M+C plan/premium the beneficiary is changing	Yes	3

[4] As explained in section 40.2, the M+C organization should decide whether it will require the beneficiary=s initials on this section of the form or consider the beneficiary signature to be adequate. If initials are required, *the beneficiary must complete Item #24.* If the M+C organization uses the signature and not initials, *the beneficiary need not complete Item #24*.

Exhibit 1: Model Individual Enrollment Form ("Election" may also be used) (4 Pages) - (Rev. 18, 01-01-03)

Referenced in section(s): 10, 40.1, 40.2, 50.1

Medicare + Choice **Plan Name:**

Your Name:_____ **Your Medicare Number:**
Date of Birth (month/day/year):_____ **Male**_____ **Female**
Permanent Residence Address:

_____ _____ _____ _____
Number, Street, Apartment # City County State Zip Code
Telephone Number: _____
Area Code Number
Mailing Address (if different from permanent address)

_____ _____ _____ _____
Number, Street, Apartment # City County State Zip Code
Name of person to contact in case of emergency [Optional field]
Phone Number: [Optional field]_____**Relationship to You** [Optional field]
[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**
___ Language A (e.g., Chinese) ___ Language B (e.g., Spanish)

Medicare Information:

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.

Medicare Health Insurance
Social Security Act

Name of Beneficiary:
Medicare Claim Number Sex
___ - __ __ - __ __ __ __
Is Entitled To Effective Date
__ Hospital Insurance (Part A)
__ Medical Insurance (Part B)

Your *Medicare + Choice* plan choice :

Please check which product you want to enroll in: [Optional field for plans with *more than* 1 product]

____ Product ABC [optional] Premium = $XX per month
____ Product XYZ [optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required): [This field is not necessary for PPOs]

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my Medicare + Choice plan coverage begins, I must get all of my health care from the Medicare + Choice plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare + Choice organization and other services contained in my Medicare + Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE *MEDICARE + CHOICE* PLAN WILL PAY FOR THE SERVICES.

[Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare +Choice plan.

Your Signature* _____ Date:

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by State law, must sign the following line. **Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date:

*If anyone helped the individual fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship to Individual:

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes _____ No

Note: If you have ESRD, you *cannot* enroll in this plan unless you are already enrolled in the *Medicare + Choice* organization as a commercial member or you were affected by the non-renewal of another *Medicare + Choice* plan after December 31, 1998. If you do not need regular dialysis any more, or have had a 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.

2. Have you recently moved into this plan's service area?

   Yes _____ No

Your answer to the following questions will <u>not</u> keep you from enrolling in this plan.

4. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes _____ No

   If yes, Name of Institution

   Address of Institution (number and street)

   Phone Number of Institution

   Your Date of Admission into Institution

5. Do you receive Medicaid benefits?

   Yes_____ (If yes, Medicaid Number: _____) No

6. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes _____ No

   If yes, what kind of insurance do you have?

   What is the name of your insurance?

7. Do you or your spouse work?

   Yes _____ No

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap/Medicare Select plan** until I get that approval from the plan. _____ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable. (Initials)

3. I understand that I can be a member of only **one *Medicare + Choice* plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other *Medicare + Choice* plan of which I am currently a member. _____ (Initials)

4. I understand that since I can be a member of only one Medicare +Choice plan at a time, I **cannot enroll in more than one *Medicare + Choice* plan** with the same effective date of coverage. If I do this, my enrollments *may* be canceled and I will have to fill out a new enrollment form to become a member of a *Medicare + Choice* plan. _____(Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.* Until the effective date of disenrollment, I must keep getting health care from the plan doctors. _____ (Initials)

6. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _____ (Initials)

7. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. (Initials)

Office Use Only:
Plan ID #:_____
Effective Date of Coverage: _____
ICEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Exhibit 2: Model Employer Group Health Plan Enrollment (the term "Election" may also be used) Form (5 Pages) - (Rev. 18, 01-01-03)

Referenced in section(s): 10, 20.4, 40, 40.1

Medicare + Choice **Plan Name**:

Effective Date (to be filled in by the plan):

Employer Name: _____ Group Number: _____

Your Name: _____ Your Medicare Number:

Date of Birth (month/day/year): _____ Male ____ Female

Permanent Residence Address:

_____ _____ _____ _____

Number, Street, Apartment # City County State Zip Code

Telephone Number: _____

Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ _____

Number, Street, Apartment # City County State Zip Code

Name of person to contact in case of emergency [Optional field]

Phone Number: [Optional field]_____**Relationship to Individual** [Optional field]

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

___ Language A (e.g., Chinese) ___ Language B (e.g., Spanish)

Are you the retiree? _____ Yes _____ No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

Are you covering a spouse or dependents under this Employer Plan? ___ Yes ____ No

If yes, name of spouse _____ Name of dependent(s) _____

Medicare Information:

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.

Medicare Health Insurance
Social Security Act

Name of Beneficiary:

Medicare Claim Number Sex

__ __ __- __ __ - __ __ __ __ __

Is Entitled To Effective Date

__ Hospital Insurance (Part A)_____

__ Medical Insurance (Part B)_____

Your *Medicare + Choice* plan choice:

_____

Are you currently a member of the Health Plan selected? _____Yes _____No

If yes, Plan Member Identification Number_____

Please check which product you want to enroll in: [Optional field for plans with *more than* 1 product]

____ Product ABC [optional] Premium = $XX per month

____ Product XYZ [optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):
[This field is not necessary for PPOs] _____

Release of Information: By joining this plan, I allow the Centers for Medicare *&* Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my *Medicare + Choice* plan coverage begins, I must get all of my health care from the *Medicare + Choice* plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the

Medicare + Choice **organization and other services contained in my** ***Medicare + Choice*** **plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE** ***MEDICARE + CHOICE*** **PLAN WILL PAY FOR THE SERVICES.** (Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers.)

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this *Medicare + Choice* plan

Your Signature* _____ Date:

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by State law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by State law**

Signature _____ Date:

*If anyone helped the individual fill out this form (with the exception of the effective date), s/he must sign the following line:

Signature _____ Date: _____ Relationship to Individual:

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes_____ No_____

   Note: If you have ESRD, you can not enroll in this plan unless you are already enrolled in the *Medicare + Choice* Organization as a commercial member or you were affected by the non-renewal of another *Medicare + Choice* plan after December 31, 1998.If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

Your answers to the following questions will <u>not</u> keep you from enrolling in this plan.

2. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes_____ No_____

   If yes, Name of Institution

   Address of Institution (number and street)

   Phone Number of Institution

   Your Date of Admission into Institution

3. Do you receive Medicaid benefits?

   Yes_____ No_____

   If yes, Medicaid Number:_____

4. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes_____ No_____

   If yes, what kind of insurance do you have?

   What is the name of your insurance?

5. Do you or your spouse work?

   Yes_____ No_____

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap/Medicare Select plan** until I get that approval from the plan. _____ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by continuing to pay the Part B premiums and the Part A premiums, if applicable. _____ (Initials)

3. I understand that I can be a member of only **one *Medicare + Choice* plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other *Medicare + Choice* plan of which I am currently a member. _____ (Initials)

4. I understand that since I can be a member of only one *Medicare + Choice* plan at a time, I **cannot enroll in more than one *Medicare + Choice* plan** with the same effective date of coverage. If I do this, my enrollments *may* be canceled and I will have to fill out a new enrollment form to become a member of a *Medicare + Choice* plan. (Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the employer benefits office, the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.* Until the effective date of disenrollment, I must keep getting health care the Medicare managed care plan. _____ (Initials)

6. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _____ (Initials)

7. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. _____ (Initials)

8. I understand that if I disenroll from this employer-sponsored plan, I will be automatically transferred to the Original Medicare Plan (fee-for-service program). Also, I understand that if I choose to enroll in a different Medicare managed care plan (whether or not it is sponsored by my employer), I will be automatically disenrolled from this employer-sponsored plan. _____ (Initials).

Exhibit 3: Model Short Enrollment Form ("Election" may also be used) (2 Pages) - (Rev. 18, 01-01-03)

This form may be used in place of the model individual enrollment form when a member of a M+C plan is enrolling into another M+C plan in the same M+CO.

Referenced in section(s): 10, 20.4, 40, 40.1

If you are changing plans within {M+CO name} you should use this form. This form may not be used to enroll in {M+CO name} for the first time.

Name of Plan You are Enrolling In:

Name: _____ **Medicare Number:**

(Note: may use "member number" instead of "Medicare number")

Permanent Address:

_____ _____ _____ _____

Number, Street, Apartment # City County State Zip Code

Telephone Number: _____

Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ _____

Number, Street, Apartment # City County State Zip Code

Please fill out the following:

I am currently a member of the _____ plan in _____{M+CO name} with a monthly premium of $_____ .

I would like to change to the _____ plan in _____ {M+CO name}. I understand that this plan has different health benefits and a monthly premium of $ _____ .

Have you recently **moved** into this plan's service area? Yes_____ No_____

Optional field, if M+CO will require the member to name a new PCP:

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my *Medicare + Choice* plan coverage begins, I must get all of my health care from my new *Medicare + Choice* plan, with the

exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the *Medicare + Choice* plan and other services contained in my *Medicare + Choice* plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE *MEDICARE + CHOICE* PLAN WILL PAY FOR THE SERVICES. (Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare +Choice plan.

Enrollee's Signature*_____ Date:

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by State law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by State law**

Signature _____ Date: _____

*If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship to Beneficiary: _____

Office Use Only:
Plan ID #: _____
Effective Date of Coverage: _____
ICEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Exhibit 3a - Model Selection Form - Switch From Plan to Plan Within M+CO - (Rev. 18, 01-01-03)

Referenced in section(s): 10, 40, 40.1, 40.2

Dear <plan name> Member:

<Introduction - In the introduction of cover letter, M+CO may include language regarding plan choices, description of plans, differences, etc.>.

If you wish to make a change in the *Medicare + Choice* plan you have with <name of M+CO> just fill out the enclosed plan benefit selection form to make your choice. Remember to check off which of the plans you want and sign the form. Then mail the completed form back to us <optional: in the postage-paid envelope> by <date>.

If you select another *plan* and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will *be* <insert premium> and you may continue to see any <current plan> primary care doctors and specialists.

The attached form should only be completed if you wish to change plans.

To help you with your decision, we have also included <year> <summary of benefits or benefit overview> for the available options.

If you have any questions, please call our Member Services Department at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings > or, for the hearing impaired, at <TDD/TTY number>. We are open {insert days/hours of operation and, if different, TTY/TDD hours of operation}. Thank you.

Plan Benefit Selection Form

Date:

Member Name:

Member Number:

I wish 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, it generally will be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>

<Cost of Premium>

<Brief description of benefit - include items such as: Visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.)

____ <Name of Plan>

<Cost of Premium>

<Brief description of benefit - include items such as: Visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.)

Signature:_____ Date:_____

Please mail this form to:

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Form - (Rev. 18, 01-01-03)

Referenced in section(s): 40.4.1, 60.4

Dear <Name of Member>:

Thank you for filling out a form to enroll in <Plan name>. Starting <effective date>, you must see your <Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. **Optional language:** This letter can serve as evidence of insurance until you get your member card from us. Until you get a member card from us, you should show this letter to your doctor when you go to your doctor appointments**.**

All enrollments have to be reviewed by the Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program. We will send your enrollment to CMS, and they will do a final review of the enrollment. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors. You should begin using <Plan> doctors on <effective date>. Also, you should not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the letter.

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you received.

Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<Plan> doctor without prior authorization, you will have to pay for the health care yourself.

** Insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain *Medicare + Choice* Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc. **

If you have any questions, please call our Member Services Department at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days/hours of operation> and, if different, <TTY/TDD hours of operation >. Thank you.

Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Form – Enrollment in Another Plan Within the Same M+CO - (Rev. 18, 01-01-03)

Referenced in section(s): 40.4.1, 60.4

Dear <Name of Member>:

Thank you for filling out a form to change your enrollment from <old Plan name> to <new Plan name>. Starting <effective date>, you must see your <new Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, ***or out-of-area dialysis services****, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care.* ***Optional language:*** *This letter can serve as evidence of insurance until you get your member card from us. Until you get a member card from us, you should show this letter to your doctor when you go to your doctor appointments.*

All enrollments have to be reviewed by the Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program. We will send your enrollment to CMS, and they will do a final review of the enrollment. When CMS finishes its review, we will send you a letter to confirm your enrollment with <new Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors. You should begin using <Plan> doctors on <effective date>.

Please remember that, except for emergency or out-of-area urgent care, ***or out-of-area dialysis services,*** *if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.*

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <TDD/TTY number>. We are open <insert days/hours of operation and, if different, TTY/TDD hours of operation >. Thank you.

Exhibit 5: Model Notice to Request Information - (Rev. 18, 01-01-03)

Referenced in section(s): 40.2.2

Dear <Name of Beneficiary>:

Thank you for your application to <M+C Plan>. We cannot process your application until we get the following things from you:

_____ Proof of Medicare Part A and B coverage. You can send us a copy of your Medicare card or a letter from Social Security or the Railroad Retirement Board as evidence of your Medicare coverage.

_____ A copy of your legal papers authorizing another person to act on your behalf.

_____ Other: _____

You will need to send this information to <M+C Plan name and address> by <date - 30 days from date letter provided to the beneficiary>. If you cannot send this information by <date listed above>, we will have to deny your request to enroll in our plan.

If you have any questions, please call our Member Services Department at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 6: Model Notice to Confirm Enrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

This letter is to tell you that the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

*N*ow that your enrollment is confirmed, you may cancel any Medigap or supplemental insurance that you have. (Please note that if this is the first time that you are a member of a Medicare + Choice plan, you may have a trial period during which you have certain rights to disenroll from <M+C Plan> and purchase a Medigap policy. Please contact 1-800-MEDICARE *(1-800-633-4227)* for further information. *TTY users should call 1-877-486-2048.*

Please feel free to call our Member Services at <phone number> *if you have any questions. TTY users should call* <TDD/TTY number>.We are open <days and hours of operation>.

Exhibit 6a: Model Notice to Confirm Enrollment - plan to plan within M+CO - (Rev. 18, 01-01-03)

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

This letter is to tell you that the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

Please feel free to call our Member Services at <phone number> *if you have any questions. TTY users should call* <TDD/TTY number>. We are open <days and hours of operation>.

Exhibit 7: Model Notice for M+C Organization Denial of Enrollment -

(Rev. 18, 01-01-03)

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying for membership in <M+C Plan>. We cannot accept your application for enrollment in <M+C Plan> because:

1. _____ You do not have Medicare Part A
2. _____ You do not have Medicare Part B
3. _____ You have End Stage Renal Disease (ESRD)
4. _____ Your permanent residence is outside our service or continuation area
5. _____ We did not receive the information we requested from you within 30 days of our request.

Medicare MSA plans add #6:

6. _____ National enrollment in Medicare Medical Savings Accounts has reached the maximum amount allowed under law

If we checked item 1 or 2, and it is correct, then we will send you a bill for any services you received. If we checked anything else and it is correct, then we may send you a bill for any services you received.

If what we checked is wrong, or if you have any questions, please call us at <phone number>.*TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 8: Model Notice for CMS Rejection of Enrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

Thank you for your recent application to <M+C Plan>. We are sorry to say that the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <M+C Plan> due to the reason(s) checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ You signed a form to enroll in a different plan for the same effective date, which canceled your application with <M+C Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare + Choice plan that you were enrolled in before you applied for membership in our plan.

If we checked number 1 or 2, and it is right, then we will send you a bill for any services you received from us.

If we checked number 3 or 4, and it is right, then we may send you a bill for any services you received from us.

If what we checked is not right, or if you have any questions, please call us at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 9: Model Notice to Send Out Disenrollment Form - (Rev. 18, 01-01-03)

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you asked for. Please fill out the whole form, sign it, and send it back to us in the enclosed envelope. *You can also fax the form to us, as long as the signature and date are readable. Our fax number is <fax number>. You may also disenroll by visiting* your local Social Security Office or Railroad Retirement Board Office, or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.*

You must keep using <M+C Plan> doctors until your disenrollment date. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <M+C plan>'s network. We will mail a copy of the disenrollment form back to you with the date of your disenrollment written on the form.

IMPORTANT NOTE ABOUT MEDIGAP RIGHTS

If you *will be changing* to *the* Original Medicare *Plan*, and any of the following situations apply to you, you might have a *special temporary* right to buy Medigap, *also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

- **Trial Periods -** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving -** If you move out of <M+C Plan>'s service area.
- **Medigap Open Enrollment -** If you are age 65 or older and you enrolled in Medicare Part B within the past 6 months.
- **Medicaid -** If you are receiving, or no longer receiving, financial assistance from the State (Medicaid) to pay for your Medicare premiums.
- Other special circumstances defined by Medicare.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never been enrolled in another *Medicare + Choice* plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage*, OR you dropped a Medigap policy less than 12 months ago to join this plan and this is the first time you have been in a Medicare + Choice plan .* Call 1-800-MEDICARE *(1-800-633-4227) for more information about trial periods.* TTY *users should call* 1-877-486-2048.

Under Federal law, if you move out of the service area and want to buy a Medigap policy, you need to apply for it no later than 63 days after the date your coverage in our plan ends. If you want to buy a Medigap policy and you are still in your trial period, you need to apply for a Medigap policy before your trial period ends or no later than 63 days after your coverage in our plan ends, whichever is earlier. If you want to buy a Medigap policy and you are in your six-month Medigap open enrollment period, you should apply before the open enrollment period ends.

Your State may have laws that provide *more* Medigap protections. Contact your State Health Insurance Program <insert name of SHIP> *at <SHIP phone number>* to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap insurance and request an application.

If you need any help, please call us at <phone number> or, for the hearing impaired, at <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Attachment

Exhibit 10: Model Disenrollment Form - (Rev. 18, 01-01-03)

Referenced in section(s): 10

NOTE TO BENEFICIARY: If you have already joined or intend to join a new Medicare managed care plan, you do not have to complete this form.

DATE_____

(Please Print in Ink)
Member's Name _____
First Middle Last
Address_____
City State Zip County
Telephone _____
Male _____ Female_____ Date of Birth_____
Medicare #_____

DISENROLLMENT RESPONSIBILITIES: **Please carefully read and complete the following information before signing and dating this disenrollment form:**

Upon the effective date of enrollment in another Medicare managed care plan, your current membership in <M+C plan name> will automatically be canceled.

Members who have requested disenrollment must continue to receive all medical care from <M+C plan name> until the effective date of disenrollment. To avoid any unanticipated expenses, you may want to contact us to verify your disenrollment before you seek medical services outside of <M+C plan>'s network. We will notify you of your effective date after we have received this form from you.

Requested Disenrollment Date:_____

_____ _____
Beneficiary Signature Date

OR

_____ _____
Beneficiary Guardian Signature Date

Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member - (Rev. 18, 01-01-03)

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <M+C Plan> and you will be disenrolled starting <effective date.> Beginning <effective date>, <M+C Plan> will not cover any health care you receive.

Until <effective date>, you must keep using <M+C Plan> doctors, except for emergencies and urgently needed care and out-of-area dialysis services. Beginning <effective date>, you can see any doctor through the Original Medicare Plan, unless you have enrolled in another *Medicare + Choice* plan.

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. You may want to tell your doctors that if they need to send Medicare claims, you just disenrolled from <M+C Plan> and there may be a short delay in having your records updated.

IMPORTANT NOTE ABOUT MEDIGAP RIGHTS

If you *will be changing* to *the* Original Medicare *Plan*, and any of the following situations apply to you, you might have a *special temporary* right to buy a *Medigap policy, also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

- **Trial Periods -** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving -** If you move out of <M+C Plan>'s service area.
- **Medigap Open Enrollment -** If you are age 65 or older **and** you enrolled in Part B within the past 6 months.
- **Medicaid -** If you are *receiving, or no longer receive,* financial assistance from the State (Medicaid) to pay for your Medicare premiums.
- Other special circumstances defined by Medicare.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never been enrolled in another *Medicare + Choice* plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage, *OR you dropped a Medigap policy less than 12 months ago to join this plan and this is the first time you have been in a Medicare + Choice plan.* Call 1-800-MEDICARE *(1-800-633-4227)* for more information about trial periods.)

Under Federal law, if you move out of the service area and want to buy a Medigap policy, you need to apply for it no later than 63 days after the date your coverage in our plan ends. If you want to buy a Medigap policy and you are still in your trial period, you need to apply for a Medigap policy before your trial period ends or no later than 63 days after your coverage in our plan ends, whichever is earlier. If you want to buy a Medigap policy and you are in your six-

month Medigap open enrollment period, you should apply before the open enrollment period ends.

Your State may have laws that provide) ***more*** **Medigap protections.** Contact your State Health Insurance Program <insert name of SHIP >) to get more information about open enrollment and trial periods; the availability of Medigap insurance in your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap insurance and request an application.

If you need any help, please call us at <phone number>.) <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing - (Rev. 18, 01-01-03)

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

This is to confirm your disenrollment from <M+C Plan.> This disenrollment began <effective date,> and <M+C Plan> will not cover any health care you receive after that date. Please note that you may want to tell your doctors that if they need to send Medicare claims, you just disenrolled from <M+C Plan> and there may be a short delay in having your records updated.

IMPORTANT NOTE ABOUT MEDIGAP RIGHTS

If you *will be changing* to the Original Medicare Plan, and any of the following situations apply to you, you might have a *special temporary* right to buy a *Medigap policy, also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

- **Trial Periods** If you are in a trial period and you disenroll from <M+C Plan> before the trial period ends.
- **Moving** - If you move out of <M+C Plan>'s service area.
- **Medigap Open Enrollment. -** If you are age 65 or older **and** you enrolled in Part B within the past 6 months.
- **Medicaid** - If you are receiving, or no longer receiving, financial assistance from the State (Medicaid) to pay for your Medicare premiums.
- Other special circumstances defined by Medicare.

You might be in a trial period if you have been enrolled in <M+C Plan> less than 12 months and you have never before been enrolled in another *Medicare + Choice* plan, OR you enrolled in <M+C plan> immediately after losing coverage under another health plan, and you were still in a trial period under the other plan when you lost coverage*, OR you dropped a Medigap policy less than 12 months ago to join this plan and this is the first time you have been in a Medicare + Choice plan.* Call 1-800-MEDICARE *(1-800-633-4227) for more information about trial periods.* (TTY *users should call* 1-877-486-2048.

Under Federal law, if you move out of the service area and want to buy a Medigap policy, you need to apply for it no later than 63 days after the date your coverage in our plan ends. If you want to buy a Medigap policy and you are still in your trial period, you need to apply for a Medigap policy before your trial period ends or no later than 63 days after your coverage in our plan ends, whichever is earlier. If you wan to buy a Medigap policy and you are I your six-month Medigap open enrollment period, you should apply before the open enrollment period ends.

Your State may have laws that provide *more* Medigap protections. Contact your State Health Insurance Program <insert name of SHIP > *at <insert SHIP phone number>* to get more information about open enrollment and trial periods; the availability of Medigap insurance in

your State; which policies you have the right to buy; the rules you must follow when applying for a policy; and any more generous protections that may apply under State law.

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap insurance and request an application.

If you think you did not disenroll from <M+C Plan>, and you want to keep being a member of our plan, please call us right away at <phone number> or, for the hearing impaired, at <TDD/TTY number> so we can make sure you stay a member of our plan. We are open <insert days and hours of operation>. Thank you.

Exhibit 13: Model Notice of Disenrollment Due to Death - (Rev. 18, 01-01-03)

Referenced in section(s): 50.2.3, 50.4.2, 60.3.1

Note: Address letter "To The Estate of <Member's Name>" or "To <Member's Name>

To The Estate of <Member's Name> (or To <Member's Name>):

The Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, has told us of the death of <Member's Name>. Please accept our condolences.

<Member's name>'s coverage in <M+C Plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will refund the Estate within 30 days of this letter.

If this information is wrong, please call us at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>.

Exhibit 14: Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B - (Rev. 18, 01-01-03)

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

We have been told by the Centers for Medicare & Medicaid Services (CMS) that you no longer have Medicare Part <insert A and/or B, as appropriate (cost plans may only insert "B")> insurance. Therefore, your membership in <M+C Plan> was ended beginning <date>. If this information is wrong, and you want to keep being a member of our plan, please contact us right away so we can make sure you stay a member of our plan. Also, if you have not already done so, please contact your local Social Security office to have their records corrected.

If you have any questions, please call us at <phone number>.*TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 15: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status - (Rev. 18, 01-01-03)

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

The Centers for Medicare & Medicaid Services has told us that their records show that you have a deceased status. But, based on our contact with you, we understand that you are alive! Obviously, there has been an error.

If you have not already done so, please go to your local Social Security Office and ask them to correct your records. Please send us <M+C Plan> written proof once this is done. When we receive this proof, we will tell the Center for Medicare and Medicaid Services to correct its records.

In the meantime, you should keep using your <M+C Plan> primary care physician for your health care. **(Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate)** Thank you for your continued membership in the <M+C Plan>.

If you have any questions or need help, please call us at < phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>.

Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination - (Rev. 18, 01-01-03)

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

On <Date of request> you told us that your enrollment in Medicare was ended in error and that you wanted to keep being a member of <M+C Plan>. As we told you, you will need to contact the Social Security Administration (SSA) to have them fix their records. You will also need to have SSA give you a letter that says the records have been fixed. Then, send the letter from SSA to us at: <address of M+C Plan>. A postage-paid envelope has been provided for your convenience. When we receive this proof, we will tell the Centers for Medicare & Medicaid Services to correct its records.

In the meantime, you should keep using your <M+C Plan> primary care physician for your health care. (**Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate)** Thank you for your continued enrollment in the <M+C Plan>. In the event that we find out that you do not have Medicare Part <insert "A" and/or "B" as appropriate>, you will have to pay for any service you received after the disenrollment date.

If you have any questions or need help, please call us at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>.

Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another M+CO - (Rev. 18, 01-01-03)

Referenced in section(s): 60.3, 60.3.2

Dear <Name of Member>:

Thank you for letting us know you want to keep being a member of <M+C Plan> after we sent you a letter that said we had disenrolled you from our plan.

Based on what you told us, we understand that you canceled your membership in the other plan and want to keep being a member of <M+C Plan>. Please send us a letter within <insert date: 30-days from the effective date of the original disenrollment>, that says you want to keep being a member of <M+C Plan>. Your letter must also say whether or not you got services from non <M+C Plan> doctors since <original effective date of disenrollment>. If you did not get any services from non <M+C Plan> doctors since <original effective date of disenrollment>, we will fix our records after we receive your letter.

In the meantime, you should keep seeing your <M+C Plan> primary care physician for your health care.(**Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate. This sentence is optional for plans that do not require PCPs)**

If you have any questions or need help, please call us at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>.

Exhibit 18: Model Notice to Close Out Request for Reinstatement - (Rev. 18, 01-01-03)

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

This letter is in response to your request that your membership in <M+C Plan> be reinstated. We cannot process your request because you have not sent us a letter asking for reinstatement. On <date of letter> we told you that you needed to send us a letter by <date placed on notice in exhibit 19>. Your letter has not been received.

The <effective date> date of disenrollment remains in effect. If you have used <M+C Plan> services after this disenrollment date, we will have to bill you for any services you received.

If you have any questions, please call <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage - (Rev. 18, 01-01-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

Our records show that we have not received payment for your plan premium as of <Date>.

M+COs who will disenroll all members (and not use the downgrade option) use the following sentence: If we do not get payment by <90 days from date of this letter>, we will have to disenroll you from <M+C Plan>. After the disenrollment you will be covered by the Original Medicare plan instead of <M+C Plan>. **Note: As required in section 50.3.1, the M+CO must state whether full payment of premiums is due to prevent disenrollment.**

M+COs who will downgrade the membership for all members use the following sentences: If we do not get payment, we will make some changes to your membership in <M+C plan name> that will reduce the amount of health care coverage you have in <M+C plan name>. What this means is that (describe lower level of benefits, e.g., prescription drugs or routing dental care will not be covered) beginning <date>. **Note: As required in section 50.3.1, the M+CO must state whether full payment of premiums is due to prevent the downgrade.**

If you *wish to* disenroll from <M+C Plan> to *the* Original Medicare *plan* now, you must tell us in writing and send your request to <M+C Plan address>. Or, you may disenroll by contacting your local Social Security District Office or Railroad Retirement Board Office, or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.*

You must keep using <M+C Plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services until you are no longer a member.

If you think we have made a mistake, or if you have any questions, please call us at <phone number> *between <hours and days of operation>. TTY users should call* <TDD/TTY number>.

Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we did not get payment from you, we would disenroll you from <M+C Plan>. Unfortunately, since we did not receive that payment, we have asked the Centers for Medicare & Medicaid Services to disenroll you from <M+C Plan> beginning <date>.

Due to your disenrollment from <M+C Plan>, you are now covered by the Original Medicare plan.

You have the right to ask us to *reconsider* this decision through the grievance procedure written in your Member Handbook.

Please note that until <disenrollment effective date>, you must keep using <M+C Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through the Original Medicare Plan, unless you join another Medicare managed care plan.

If you think that we have made a mistake or if you have any questions, please call us at *<phone number> between <hours and days of operation>. TTY users should call* <TTY/TDD number>.

Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

We have received confirmation from the Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, of your disenrollment from <M+C Plan> due to non-payment of plan premium. Your disenrollment begins <effective date>.

Due to your disenrollment from <M+C Plan>, you are now covered by the Original Medicare plan.

You have the right to ask us to *reconsider* your disenrollment through the grievance procedure written in your Member Handbook.

If you have any questions about this action, or need help in any way, please call us at <phone number> *between <hours and days of operation>.TTY users should call* <TDD/TTY number>.

Exhibit 22: Model Notice on Failure to Pay Plan Premiums - Notice of Reduction in Coverage - (Rev. 18, 01-01-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we did not get payment from you, we would have to make some changes in your membership in <M+C Plan>. Our records show that we did not get payment from you as of <Date>. Therefore, we have reduced your coverage in <M+C Plan>, beginning <effective date.>

Your new benefits <Explain lower level of benefits, e.g., prescription drugs or routing dental care will not be covered>

Please note that unless you disenroll from <M+C Plan>, you must keep using <M+C Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services.

You have the right to ask us to reconsider this change through the grievance procedure written in your Member Handbook.

If you want to disenroll from <M+C Plan> now, you must tell us in writing and send your request to <M+C Plan address>. Or, you may disenroll by contacting your local Social Security District Office or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.(1-800-633-4227).*

If you think we have made a mistake, or if you have any questions, please call us at <phone number> *between <hours and days of operation>. TTY users should call* <TDD/TTY number>.

Exhibit 23: Model Notices For Closing Enrollment (2 pages) - (Rev. 18, 01-01-03)

Referenced in section(s): 30

Model A: Closing Enrollment for Partial Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer continuous open enrollment under its *Medicare + Choice* contract with the Centers for Medicare & Medicaid Services for [insert plan name] in [insert service area].

Instead, [insert name of M+C organization] will offer open enrollment for all eligible individuals from the [insert date] to the [insert date] of each month.

[Insert name of M+C organization] will continue to accept enrollments during an entire month into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from all eligible individuals during the entire month.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] *between <insert days and hours of operation>. TTY users should call* <insert TTY/TDD number>.

Model B: Closing Enrollment for Whole Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer open enrollment under its *Medicare + Choice* contract with the Centers for Medicare & Medicaid Services for [insert plan name] in [insert service area].

However, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from **all** eligible individuals.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] *between [insert days and hours of operation]*.TTY *users should call* [insert *TTY/TDD* number].

Model C: Closing Enrollment for Capacity Reasons

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date], [insert name of M+C organization] will no longer accept enrollment under its *Medicare + Choice* contract with the Centers for Medicare & Medicaid Services for [insert plan name] in [insert service area].

The [insert plan] has been approved for a capacity limit by the Centers for Medicare & Medicaid Services. A capacity limit allows a *Medicare + Choice* Organization to limit enrollment in a plan once a specific number of people join the plan. This is based primarily on the accessibility and availability of providers to provide services to members of the plan.

Current members of [insert name of plan] are not affected by this change. Also, individuals who are enrolled in other [insert organization name] plans may still be able to enroll in [insert name of plan] when they become eligible for Medicare.

For information regarding this notice, call [insert name of M+C organization] at [insert phone number] *between [insert days and hours of operation]*. TTY *users should call* [insert number].

Exhibit 24 - Model Notice for Medigap Rights Per Special Election Period - (Rev. 18, 01-01-03)

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled effective <insert date> as a result of special circumstances. You requested disenrollment from our plan to return to Original Medicare because:

1. _____ You permanently moved.
2. _____ You receive assistance from the Medicaid program.
3. _____ You wanted to use certain Medigap protections while in your trial period.
4. _____ Other circumstance defined as eligible for a Special Election Period.

Please save this letter as proof of your Medigap rights.

If you have any questions, please call us at <phone number>. *TTY users should call* <TDD/TTY number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 25 - Acknowledgement of Request to Cancel Enrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 60.2.1

Dear <Member>:

As requested, we have processed your request to cancel your enrollment with <name of plan>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in Original Medicare, you may want to tell your providers that if they need to submit Medicare claims for any health care you received from them, there may be a short delay in having your records updated.

If you were enrolled in another *Medicare + Choice* Plan before enrolling with <plan>, you may appear on their records as being disenrolled. If your intent is NOT to disenroll with that plan, you will need to notify them that you enrolled in <plan> and have cancelled your enrollment. They may request a copy of this letter for their records.

If you have any questions, please contact <plan> customer service at *<insert number>,* Monday through Friday between the hours of <insert hours>. *TTY users should call <insert TTY/TDD number>.*

Exhibit 26 - Acknowledgement of Request to Cancel Disenrollment - (Rev. 18, 01-01-03)

Referenced in section(s): 60.2.2

Dear <Member>:

As requested, we have processed your request to cancel your disenrollment with <insert name of plan>. You should keep using your <M+C Plan> primary care physician for your health care. (Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate) Thank you for your continued membership in the <M+C Plan>.

Please be patient. It may take up to 45 days for Medicare to update your records. You may want to tell your providers that if they need to submit Medicare claims for any health care you received from them, there may be a short delay in having your records updated.

If you have also submitted an enrollment with another *Medicare + Choice* Plan, you may appear on their records as being enrolled. If your intent is NOT to enroll with that plan and maintain enrollment in <our plan>, you will need to notify them that you are *canceling* enrollment in their plan. They may request you write them a letter for their records.

If you have any questions, please contact <plan> customer service at *<insert number>,* Monday through Friday between the hours of <hours>. *TTY users should call <insert TTY/TDD number>.*