DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE ENROLLMENT & APPEALS GROUP

DATE: June 15, 2017

TO: All Medicare Advantage, Prescription Drug Plan, Cost, PACE, and Demonstration Organizations

FROM: Jerry Mulcahy
Director

SUBJECT: Model Enrollment Form Changes for Contract Year 2018

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires that CMS remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards, which will be issued to beneficiaries no earlier than April 2018. The purpose of this memorandum is to provide technical edits to the model enrollment form exhibits in Chapters 2 and 17D of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual to address the operational changes resulting from the shift from HICN to MBI.

The April 13, 2017 Health Plan Management System (HPMS) memorandum titled "Announcement of the May 2017 Software Release," outlined that while CMS transitions to the MBI (April 2018 to December 2019), sponsors will be able to submit data to the Medicare Advantage and Prescription Drug (MARx) system using either the HICN or MBI on all input transaction types. Likewise, beneficiaries may use either the HICN or MBI when completing an enrollment request during this transition period. To account for either number being used in the enrollment process during the transition period, the language in the model enrollment form exhibits have been modified to change the term from "Medicare Claim Number," to "Medicare number" to refer to the number assigned to a Medicare beneficiary.

We also note that the design of the Medicare card will be changing and will be effective when the CMS begins to mail new MBI cards in 2018. To address this change, we are removing the picture of the Medicare card from the model enrollment form exhibits and replacing it with text to capture only the needed information from the Medicare card: the name as printed on the card (in order to make a positive match in our systems), the Medicare Number, and the Medicare coverage effective dates. We note that gender is not being requested in this section, as it is already requested earlier in the form.

Additionally, the MBI will be a random and unique number that has no inherent logic to differentiate between beneficiaries receiving Social Security or Railroad Retirement Board (RRB)

benefits. To help sponsors process premium withhold requests efficiently, we have added a question for the applicant to select whether they receive monthly benefits from Social Security or the RRB. As this premium payment information is not required in order for the enrollment to be processed, the response to this question is optional by the applicant.

Sponsors will need to make edits to the enrollment mechanisms they use to add the premium withhold question and to accurately collect the Medicare number, whether it be a HICN or MBI. These modifications need to be made before April 2018 to eliminate any possible confusion by beneficiaries who may be seeking enrollment and have a new Medicare card with an MBI.

Although these modifications are not necessary for enrollments with effective dates prior to April 2018, sponsors may implement these changes sooner.

CMS will not require resubmission of previously approved/accepted enrollment forms for changes outlined in this memorandum. Any other changes other than those outlined in this memorandum must be submitted to HPMS.

The changes noted in the attached model enrollment form exhibit are applicable to all the model enrollment forms in the enrollment guidance. The updated model enrollment form exhibits will be incorporated into the Chapter 2 and Chapter 17D of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual. These chapters will be posted at the links below within 10 business days of this memorandum.

- MA and Cost Plan enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html
- PDP enrollment guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html

Additional guidance updates for contract year 2018 will be released under a separate memorandum; these updates will not impact the model enrollment form exhibits.

Please direct questions regarding the submission or review of member materials to your CMS Account Manager. For enrollment policy questions, please submit your inquiry to PDPENROLLMENT@cms.hhs.gov and copy your CMS Account Manager. For information about the Social Security Number Removal Initiative, visit https://www.cms.gov/medicare/ssnri/index.html.

Exhibit 1: Model MA Individual Enrollment Request Form ("Election" may also be used)

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

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number: ( )]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field*: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled To: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.

[***Zero premium MA-only plans may omit this section***:

Paying Your Plan Premium

[*Zero premium MA-PD plans insert the following***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail,** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium** [*MA-PD plans with premiums insert:* **(including any late enrollment penalty that you currently have or may owe)] by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.]**

[*MA-PD plans with premiums insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <option: "coupon", "payment" book, etc>
<*option to include other billing intervals e.g. bi-monthly, quarterly*>

[*Optional - Include other payment methods, such as EFT & credit card, as follows:*

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)]

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

[*MA-PD plans insert:*

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

Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for this coverage: Group # for this coverage

_____ _____
_____]

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? □ Yes □ No

[Special Needs Plans insert question(s) regarding the required special needs criteria (i.e. "Do you live in a long term care facility" or "Do you have diabetes?"]

[*Optional field:* **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ <include list of available languages>

____ <include list of other formats (like Braille, audio tape, or large print) >

Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number.>

[***Following box required only for MA-PD plans*:**

Please Read This Important Information

If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits. You could lose your employer or union health coverage if you join <MA-PD name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

<Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***MA-only plans insert*:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. [*PPOs use the following in place of the first sentence:* "I understand that beginning on the date <plan name> coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, <plan> provides refunds for all covered benefits, even if I get services out of network."] Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <PLAN NAME> WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that <plan name> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

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

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]