

2022 Providence Medicare Advantage Plans Plan Change Form

Dear Providence Medicare Advantage Plans Member:

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

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

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

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

To help you with your decision, we have also included 2022 Summary of Benefits for the available options online.

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

Thank you.

Providence Medicare Advantage Plans

Plan Change Form

DATE _____ LAST NAME _____ FIRST NAME _____ MI _____ MEMBER NUMBER _____

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

Please check the appropriate box below:

Providence Medicare Dual Plus (HMO D-SNP)*

Monthly Premium Amount: \$0	Primary Care Provider visit: + In-Network: 0% of the cost for each visit	Inpatient Hospital Coverage: + In-Network: \$0 copay for each benefit period	Emergency Care: 0% of the cost
Out-of-Pocket Max: + In-Network: \$3,400	Specialist visit: + In-Network: 0% of the cost for each visit		Ambulance: 0% of the cost

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

OFFICE USE ONLY

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

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

PBP _____ TRAN. CODE _____ PREMIUMS _____ GROUP # _____ CONTRACT # _____

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

- Braille
- Large print
- Audio CD

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

SIGNATURE

_____/_____/_____
TODAY'S DATE

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

NAME

ADDRESS

CITY

COUNTY (OPTIONAL)

STATE

ZIP CODE

PHONE NUMBER

RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:

Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:

503-574-8653

Scan and email pages to:

provMedicare@providence.org

 **AGENT USE ONLY**

AGENT NAME

_____/_____/_____
DATE

NPN #

_____/_____/_____
REQUESTED DATE OF
COVERAGE

Race/Ethnicity Questionnaire

The following questions will help us to better serve all communities. These questions are optional.

Which of the following describes your racial or ethnic identity?

Please check all that apply.

Hispanic or Latino/a/x

- Hispanic or Latino/a/x Central American
- Hispanic or Latino/a/x Mexican
- Hispanic or Latino/a/x South American
- Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- Guamanian or Chamorro
- Marshallese
- Communities of the Micronesian Region
- Native Hawaiian
- Samoan
- Tongan
- Other Pacific Islander

Other

- Other
- Don't know
- Don't want to answer

American Indian or Alaska Native

- American Indian
- Alaska Native
- Canadian Inuit, Metis, or First Nation
- Indigenous Mexican, Central American, or South American

White

- Caucasian/White (no national affiliation)
- Eastern European
- Western European
- Other White (African, Australian, New Zealand descent)
- Slavic

Middle Eastern or North African

- Middle Eastern
- North African

Black or African American

- African American
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- Afro-Latinx/Biracial/Other
- Other Black

Asian

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- Yes** (please specify): _____
- No:** I do not have just one primary racial or ethnic identity.
- No:** I identify as Biracial or Multiracial.
- N/A:** I only checked one category above.
- N/A:** I don't know.
- N/A:** I don't want to answer.

What is your preferred spoken language?

- English
- Spanish
- Chinese - Other
- Mandarin
- Cantonese
- Vietnamese
- Russian
- German
- French
- Tagalog
- Japanese
- Korean
- Arabic
- Decline/Unknown
- Other