OMB No. 0938-1378 Expires: 12/31/2026

Enrollment Request Form

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area (Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties)

Important: To join this Medicare Advantage Special Needs Plan, you must also have:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicaid (Full Medicaid only)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Starts 3 months before you get Medicare, the month that you become eligible for Medicare, and 3 months after your Medicare becomes effective
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your Medicaid (AHCCCS) card
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

By mail: Health Choice Pathway (HMO D-SNP)
Attn: HCP Enrollment Dept.
8220 N. 23rd Avenue
Phoenix, AZ 85021

By email: HCHPathwayEnrollment@azblue.com

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Health Choice Pathway at **1-800-656-8991.** TTY users can call **711,** 8 a.m. to 8 p.m., 7 days a week. Or, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users can call **1-877-486-2048.**

En español: Llame a Health Choice Pathway al **1-800-656-8991, TTY: 711,** 8 a.m. to 8 p.m., los 7 dias de la semana o a Medicare gratis al **1-800-633-4227** y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

SECTION 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join: ☐ Health Choice Pathway – $0 per month

Name (as it appears on your Medicare card)

FIRST name: _____ LAST name: _____ Middle Initial: _____

Birth date: (MM/DD/YYYY)	Sex:	Mobile phone number:
(/ /)	☐ Male ☐ Female	( ) Alternate phone number: ( )

Permanent Residence street address (Don't enter a PO Box):
Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.

Street address: _____

City: _____ State: _____ ZIP Code: _____ County: _____

Mailing address, if different from your permanent address (PO Box allowed):

Street address: _____ City: _____ State: _____ ZIP Code: _____

Your Medicare information:

Medicare Number: ___ ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Health Choice Pathway? ☐ Yes ☐ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

1. Are you enrolled in your State Medicaid program (AHCCCS)? ☐ YES ☐ NO

   If yes, please provide your Medicaid number: _____

2. 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: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Health Choice Pathway.
- By joining this Medicare Advantage Plan, I acknowledge that Health Choice Pathway will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Health Choice Pathway coverage begins, I must get all of my medical and prescription drug benefits from Health Choice Pathway. Benefits and services provided by Health Choice Pathway and contained in my Health Choice Pathway "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Health Choice Pathway will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	Address:
Phone number:	Relationship to enrollee:

Important: If you are signing as an authorized representative under a Power of Attorney, you must include a copy of the legal Health Care Power of Attorney documentation with this application. Failure to provide this documentation will result in an incomplete application and may delay or prevent enrollment.

SECTION 2 – All fields in this section are optional

Answering these questions is your choice.
You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English. ☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Health Choice Pathway at **1-800-656-8991** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week. TTY users can call **711.**

Do you work? ☐ Yes ☐ No | Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

_____

Address: _____

☐ By checking this box, I agree to opt in to receive emails and/or texts with information about my enrollment, health programs, and other plan services. I understand I may change my email and text preferences and opt out at any time by calling **1-800-656-8991, TTY: 711.**

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Summary of Benefits ☐ Comprehensive Formulary
☐ Provider Directory ☐ Pharmacy Directory ☐ Over-the-Counter Catalog

Email address: _____

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30, and 423.32 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Health Choice Pathway the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____	Relationship to enrollee: _____
Signature: _____	National Producer Number: _____ (Agents/Brokers only)

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment): _____

Agent/broker number: _____

Date enrollment form was received if mailed/faxed to agent: _____

Proposed effective date of coverage: _____

☐ AEP ☐ ICEP ☐ IEP ☐ MAOEP ☐ SEP

SEP Code *(Required if SEP selected):*	SEP Date:

Paper enrollment: ☐ **Telephonic enrollment:** ☐ **Electronic enrollment:** ☐

Reminder: If the application is signed by an authorized representative under a Health Care Power of Attorney, a copy of the Power of Attorney documentation must be included. Applications submitted without this documentation will be deemed incomplete.

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