MyCareOhio
Connecting Medicare + Medicaid

INDIVIDUAL ENROLLMENT REQUEST FORM

COMPLETE THIS FORM AND MAIL TO:
Ohio Medicaid Consumer Hotline
505 South High Street, Suite 200
Columbus, Ohio 43215
or **FAX TO**: (614) 280-0977
QUESTIONS? Call (800) 324-8680

To enroll in a MyCare Ohio Plan, you must have **Medicare Part A (Hospital Insurance)**, **Medicare Part B (Medical Insurance)**, and **Ohio Medicaid**

1. Choose the Medicaid Plan you wish to enroll in:
[Check the box next to the plan you want to enroll with.]

☐ Anthem BCBS ☐ CareSource ☐ Molina

Your information

Please fill in the spaces below. Be sure to print clearly.

Your Name [First, Middle and Last]			
Phone Number:	Second phone number:	Email address:	
Home address:			
City:	State:	Zip Code:	County:

Emergency contact name:	Emergency contact phone number:
Medicaid Billing Number	Case Number

2. Tell us where you usually get health services:

(Please Print Clearly)

Name of primary care provider, clinic, or health center
Primary care provider phone Number:

3. If you would like your MyCare plan to cover both your Medicare and Medicaid services, please contact the plans directly at the numbers listed below.

Anthem Blue Cross and Blue Shield: 1-833-727-2169
CareSource: 1-844-607-2830
Molina Healthcare of Ohio: 1-844-293-2891

4. To get more information:

- If you have questions about Medicare, you can call **800-MEDICARE (800-633-4227)** 24 hours a day, seven days a week or visit http://www.medicare.gov. TTY users should call 877-486-2048.

- The Office of the State Long-term Care Ombudsman advocates for consumers receiving long-term services and support. For MyCare Ohio members, help

with concerns about any aspect of care is available through the MyCare Ohio Ombudsman. Help is available to gather information about your options, protect rights and file complaints or appeals with any

health plan. Contact an ombudsman by calling 800-282-1206 (TTY Ohio Relay Service: 800-750-0750), Monday through Friday 8 a.m.- 5 p.m. You can also contact an ombudsman by emailing MyCareOmbudsman@age.ohio.gov.

- The Ohio Senior Health Insurance Information Program (OSHIP) provides free, objective information about Medicare plans available to you. Contact OSHIP by calling (800)686-1578, Monday through Friday 8 a.m. to 5 p.m. You can also contact OSHIP by emailing OSHIPmail@insurance.ohio.gov.

5. Please read and sign below.

When you sign this form, it means you understand the following:

- MyCare Ohio plans have a contract with the federal government and with Ohio.
- The health services you get with your new plan may be different than the services you had before.
- I must keep Part A, Part B, and Ohio Medicaid.
- I can be in only one Medicare plan at a time.
- I must tell Medicare and Ohio Medicaid about any prescription drug coverage that I have or may get in the future.
- If I move, I need to tell my county case worker.
- As a member of MyCare Ohio, I have the right to appeal if I don't agree with my plan's decisions about payment or services.
- I understand that my MyCare Ohio plan's member handbook includes the rules I must follow.
- The MyCare Ohio doesn't usually cover people while they're out of the state, but there may be some limited coverage across the Ohio state border.
- On the date my coverage begins, I must get my health care from my plan's providers, except for emergency or urgently needed care.
- My plan will cover my health care with their network providers and other providers as outlined in their member handbook.
- By enrolling in a MyCare Ohio plan, I know that my plan may share my information with Medicare and Ohio Medicaid and other plans as necessary for treatment, payment, and health care operations.
- I understand that prescription drugs are covered, but not always the same ones I'm already

taking. I understand I'll have access to my current drugs for at least 30 days, until I can switch to different drug.

- I know that my MyCare Ohio plan may share my information, including my prescription drug event data, with Medicare and Ohio Medicaid. They may release it for research and other purposes, as allowed by federal statutes and regulations.
- The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from MyCare Ohio.
- My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Ohio Medicaid.

Your signature:_____ Date: _____

You can mail this form to:
Ohio Medicaid Consumer Hotline
505 South High Street, Suite 200
Columbus, Oh 43215

Information about your authorized representative, if applicable:

Name: _____

Signature: _____

Date: _____

Address: _____

Phone number: _____

Relationship to person with Medicare and Medicaid:

_____

If you need more information, have questions, or need any assistance with this form such as translation, call the Ohio Medicaid Consumer Hotline at (800) 324-8680, Monday through Friday 7:00 a.m. to 8:00 p.m. and Saturday 8:00 a.m. to 5:00 p.m., or visit www.ohiomh.com.