



INDIVIDUAL ENROLLMENT REQUEST FORM

If you need assistance with this form, contact us:
OHIO MEDICAID CONSUMER HOTLINE: (800) 324-8680
Monday - Friday: 7 a.m. to 8 p.m. and Saturday : 8 a.m. to 5 p.m.
www.ohiomh.com

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 Medicare-Medicaid Plan you wish to enroll in:

[Check the box next to the plan you want to enroll with.]

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2. Your information

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

Your Name [first, middle, last]			
Phone Number:	Second phone number:	Email address:	
Home address:			
City:	State:	Zip Code:	County:
Emergency contact name:		Emergency contact phone number:	

3. 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:

4. Tell us about your Medicare & Medicaid coverage:

Fill in your Medicare and Medicaid information below. You can find this information on your red, white, and blue Medicare card, or a notice from Social Security or the Railroad Retirement Board. Also, please put your Medicaid ID number as it appears on the front of your card.

Name: _____	
Medicare Claim Number	
____ - ____ - ____ - ____ - ____	Sex _____
Is entitled to:	Effective Date [MM-DD-YYYY]
HOSPITAL (Part A)	____ / ____ / ____
HOSPITAL (Part B)	____ / ____ / ____

Medicaid ID number: _____

5. Tell us how you want to receive your care:

- I want MyCare Ohio to provide **BOTH** my Medicaid and Medicare services.
- I want MyCare Ohio to provide my Medicaid services **ONLY**.

6. Please read and sign below.

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

<ul style="list-style-type: none">• 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.• By enrolling in MyCare Ohio, I'll end my enrollment in another Medicare health or prescription drug plan.• 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 caseworker.• 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 plans 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.	<ul style="list-style-type: none">• If I need to see a provider or other provider who isn't in in my plan's network, I may need prior authorization or I may have to pay out-of-pocket for the services I get.• 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.
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Your signature: _____

Date: _____

Information about your authorized representative, if applicable:

If you're the authorized representative, you must provide the following information, sign, and date below.

Name: _____
[Please print.]

Signature: _____

Date: _____

Address: _____

Phone number: _____

Relationship to person with Medicare and Medicaid: _____

For more information or questions, call the Ohio Medicaid Consumer Hotline at (800) 324-8680 Monday through Friday 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m. or visit www.ohiomh.com

Notice of Nondiscrimination

The Ohio Department of Medicaid complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Ohio Department of Medicaid does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Ohio Department of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Ohio Medicaid Consumer Hotline at 800-324-8680.

If you believe that the Ohio Department of Medicaid has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Ohio Department of Medicaid
P.O. Box 182709
Columbus, Ohio 43218-2709
614-466-4693

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-324-8680.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-324-8680.

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請電 1-800-324-8680。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-324-8680.

Arabic: مرقب لصتا . ناجرلاب كل رفاوتت ةيوغللل ةدعاسرلا تامرذخ نإف ، ةغلللا ركذا ثدحتت تنك اذا : ةظوحلمر 1-800-324-8680.

Pennsylvanian Dutch: Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-324-8680.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-324-8680.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-324-8680.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-324-8680.

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattan Oroomiffa yoo ta'e tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argattu. Bilbilaa 1-800-324-8680.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-324-8680 번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-324-8680.

Japanese: 注意事項: 日本語を話される場合、無料の通訳サービスをご利用いただけます。1 ☒800☒324☒8680まで、お電話にてご連絡ください

Dutch: AANDACHT: Als u Nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-324-8680.

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-324-8680.

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-324-8680.

Somali: OGAYSIIN: Haddii aad ku hadasho Soomali, adeegyada gargaarka luqada, oo bilaasha , ayaad heli kartaa. Wac 1-800-324-8680.

Nepali: ध्यान दनुहोस्: यदतिपाईले नेपाली बोल्नुहुन्छ भने तपाईंको नमितिभाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छन् । 1-800-324-8680 मा फोन गर्नुहोस् ।