



Enrollment Form Instructions

To be eligible for Mercy Care Advantage (HMO SNP), you must receive Medicaid medical assistance from the State of Arizona, have Medicare Parts A and B, be a United States citizen or be lawfully present in the U.S. and reside in the Plan approved service area.

Our Plan service areas for the following Medicaid programs include:

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| AHCCCS Complete Care (ACC) | Gila, Maricopa, and Pinal counties |
| ALTCS | Gila, Maricopa, Pima and Pinal counties |
| Arizona Division of Developmental Disabilities | All counties in the State of Arizona |

If you lose your Medicare or Medicaid eligibility, Mercy Care Advantage is required to end your coverage.

SECTION 1:

- You must complete all items in Section 1.
- Complete your Name (as it reads on your Medicare Card), Date of Birth, Telephone number, and Permanent Residence address.
- If you want to join our plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic or the address where you receive mail may be considered your permanent residence address.
- Complete your e-mail address (optional).
- Complete the Mailing Address only if your mail is delivered to a different address.
- Provide your Medicare health insurance information from your Medicare card or attach a copy of your Medicare card or other proof of Medicare eligibility.
- Please read and answer all the questions.
- Provide your Medicaid health insurance information from your AHCCCS ID card.
- Read your agreement carefully; it is important for you to understand your rights and responsibilities as a Mercy Care Advantage member.
- Sign and date your application.
- Authorized Representatives: If you have legal authorization to sign on the enrollee's behalf, please provide your contact information in the area indicated. It is recommended that you include a copy of the legal documentation (e.g. Durable General Power of Attorney; Legal Guardianship; or Conservatorship) so that we can record this information in our systems for future interactions you will have with our plan on behalf of the enrollee.

SECTION 2:

- The items in Section 2 are optional to complete, but we encourage you to respond.
- Write in the name of your Primary Care Physician (PCP) – refer to the Mercy Care Advantage Provider/Pharmacy Directory. If you do not select a PCP, we will assign one located near where you live.
- Tell us if you need plan information in a language other than English (or in an accessible format).
- Please tell us if you are a resident of a nursing home or long-term care facility.
- Please tell us if you or your spouse are working.
- Please select options for your race, ethnicity, or select “I choose not to answer”.
- Please read the Privacy Act Statement.
- Please read and complete the Attestation of Enrollment Eligibility Period section if you are enrolling outside of the Medicare Annual Election Period (AEP) (**October 15th through December 7th**). During the last quarter of the year, the AEP allows you to make a Plan election for a January 1 effective date.
- There is a Special Election Period (SEP) for Dual Eligible Beneficiaries that allows one enrollment change per calendar quarter during the first nine months of the year. There are other Special Election Periods that may apply to your enrollment situation.
- Please check the box(es) that apply to you. If we need additional information, a representative will contact you.

Return your completed Enrollment form in the Self-Addressed Postage Paid envelope provided or fax it to 602-431-7499.

Should you have questions or need help completing this form, please call:

602-414-7630 or 1-866-571-5781 (TTY 711)
8:00 a.m. – 8:00 p.m., 7 days a week

Mercy Care Advantage is an HMO SNP with a Medicare contract and a contract with the Arizona Medicaid Program. Enrollment in Mercy Care Advantage depends on contract renewal.