MyCareOhio
Connecting Medicare + Medicaid

INDIVIDUAL ENROLLMENT REQUEST FORM

To join a MyCare Ohio managed care plan, you must have:
MEDICAID and **MEDICARE PART A** and **PART B**

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

1. Choose your MyCare Ohio plan here:
[Check the box next to the plan you want to enroll with.]

☐ CareSource

☐ Buckeye

☐ United

2. Tell us about yourself:
[Please fill in the spaces below. Please print clearly.]

Your Name [first, middle, last]:			Sex: ☐ Male ☐ Female
Date of Birth: _ _/_ _/_ _ _ _ [m m d d y y y y]	Phone Number (_ _ _) _ _ _-_ _ _ _	Alternate Phone Number (_ _ _) _ _ _-_ _ _ _	
Your E-mail Address:			
Your Address [Where you live]:			
City:	State:	Zip Code:	County:
Your Mailing Address [If you receive mail at a different address from where you live, enter that address here]:			
City:	State:	Zip Code:	County:
Name of Emergency Contact:			Emergency Contact's Phone Number (_ _ _) _ _ _-_ _ _ _

3. Tell us where you usually get your health care services:

[Please print clearly.]

Name of your Primary Care Doctor, Clinic, or Health Center: [Please use your doctor's first and last name]
Phone Number (_ _ _) _ _ _ - _ _ _ _

4. Tell us about your Medicaid and Medicare coverage:

[Fill in your Medicaid and Medicare information below.]

Your **MEDICAID** Coverage

Complete the sample Ohio Medicaid card below.

[Please write your Medicaid ID number exactly as it appears on the front of your actual Ohio Medicaid card.]

Billing Number
Eligible Individual
Date of Birth
Medicare Number
TPL - Other Insurance Codes

Your **MEDICARE** Coverage:

Complete the sample Medicare card below.

[You can find your Medicare information on your red, white, and blue Medicare card or on a letter from Social Security.]

NAME:______________________

MEDICARE CLAIM NUMBER: SEX:________

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

IS ENTITLED TO:	EFFECTIVE DATE:
HOSPITAL (Part A)	____/____/_______
MEDICAL (Part B)	____/____/_______

5. How do 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.**

Please read the information on the next page and sign in the signature box.

Your signature in the box below means that you understand the following:

- MyCare Ohio plans have a contract with the federal government and with Ohio Medicaid.
- The health services you get with your new plan may be different from the services you had before.
- You must keep Medicare Part A, Part B, and Ohio Medicaid to participate in the program.
- You can only be in one Medicare plan at a time.
- By joining a MyCare Ohio plan, you will end you enrollment in another Medicare health or prescription drug plan.
- You must tell Ohio Medicaid and Medicare about any prescription drug coverage that you have now or may get in the future.
- If you move, you need to tell your county caseworker.
- As a MyCare Ohio plan member, you have the right to appeal if you do not agree with the decisions your plan makes about payment or services.
- On the date your coverage begins, you must get your health care from doctors avaialble through your health plan - except for emergency or urgently needed care.
- If you need to see a doctor or other provider who is not in your plan, you may need to request prior authorization or you may have to pay out-of-pocket for the services you get.
- By joining a MyCare Ohio plan, you know that the plan may share your information with Medicare and Medicaid and other providers as necessary for treatment, payment, and health care operations.
- You understand that your plan covers prescription drugs, but not always the same drugs you already taking. You understand that you will have access to your current drugs for at least 30 days, until you can switch to a different drug.
- You know that your plan may share your information - including my prescription drug information - with Medicare and 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 your knowledge. You understand that if you intentionally provide false information on this form, you will be disenrolled from the plan.
- Your signature (or your authorized representative's signature) on this form means that you have 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 Medicaid.

SIGNATURE:	DATE: _ _ /_ _ /_ _ _ _ [m m d d y y y y]

If you are signing this form as the authorized representative, sign above and complete the information below:

PRINT YOUR NAME:	DATE: _ _ /_ _ /_ _ _ _ [m m d d y y y y]
YOUR ADDRESS:	
RELATIONSHIP TO ENROLLEE:	PHONE NUMBER: (_ _ _) _ _ _ - _ _ _ _