HealthPartners®

HealthPartners® Inspire (SNBC) Enrollment Form

Please fill out and sign this form to enroll in HealthPartners® Inspire (SNBC).
Return your signed, completed form in the enclosed self-addressed envelope to:

HealthPartners
Riverview Membership Accounting, MS21103R
P.O. Box 9463
Minneapolis, MN 55440

Or fax it to: 952-853-8746

HealthPartners Enrollment Telephone Numbers
952-967-7264 or 888-347-7264. TTY for the hearing impaired at 952-883-6060 or 800-443-0156.
Monday through Friday, 8 a.m. to 6 p.m.
The call is free.

HealthPartners Member Services Telephone Numbers
952-967-7998 or 866-885-8880. TTY for the hearing impaired at 952-883-6060 or 800-443-0156.
Monday through Friday, 8 a.m. to 6 p.m.
The call is free.

You can speak to someone about getting this information for free in other languages. Call the Member Services numbers above. The call is free.

HealthPartners®

Office Use Only:
Date: _____
Name of Authorized Sales Person _____

HealthPartners® Inspire (SNBC) Enrollment Request Form

Name: (first, middle, last)			
Birth date: (___ ___/___ ___/___ ___ ___ ___) **M M D D Y Y Y Y**			**Sex: ☐ Female ☐ Male**
Phone number: (_____) _____ - _____	**Social Security Number (Optional):**		**Email address (Optional):**
Address where you live (P.O. Box is not allowed):			
City:	**State:**	**ZIP code:**	**County:**
Address where you get mail (if different from where you live):			
City:	**State:**	**ZIP code:**	**County (Optional):**
Case number:		**Medical Assistance ID#**	

Do you need an interpreter? ☐ **Yes** ☐ **No** If YES, check one of the boxes below:

☐ Spanish (01) ☐ Hmong (02) ☐ Vietnamese (03) ☐ Khmer (Cambodian) (04) ☐ Lao (05) ☐ Russian (06)

☐ Somali (07) ☐ ASL (American Sign Language) (08) ☐ Arabic (10) ☐ Serbo-Croatian/Bosnian (11)

☐ Oromo (12) ☐ (98) Other, explain: _____

Do you have other health insurance? ☐ **Yes** ☐ **No** If YES, please provide your other insurance information:

Insurance company name: _____

Policyholder's name: _____ Policy number: _____

By completing this form, I agree to the following:

HealthPartners will be providing my health care covered by Medical Assistance.
As a member of HealthPartners® Inspire (SNBC), I have the right to ask about my health plan's decision about payment or services. I may appeal if I disagree.
I will be notified of the date my coverage will start.
If I do not receive all of my covered health care from HealthPartners network providers, then HealthPartners will not pay for services, except in an emergency or for urgently needed services.
I will read the Evidence of Coverage I get from HealthPartners; it will have the rules I must follow and more information about covered services authorized by my plan. Services authorized by HealthPartners and other services contained in my HealthPartners Evidence of Coverage will be covered. Without authorization, **HEALTHPARTNERS WILL NOT PAY FOR THE SERVICES.**
My HealthPartners benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave HealthPartners® Inspire (SNBC) at any time and change back to Medical Assistance fee-for-service, effective the first of the following month. If I do leave, I understand that I will be enrolled in HealthPartners SNBC through the last day of the month.
To be enrolled and stay enrolled in HealthPartners® Inspire (SNBC), I must: • Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT). • Be at least 18, and under age 65 at the time of enrollment. • Be eligible for Medical Assistance. • Have Medicare Parts A **and** B, OR no Medicare. • Live in the HealthPartners® Inspire (SNBC) service area. If any of this changes, I will notify HealthPartners so I can disenroll.

By enrolling in this plan, I authorize:

The State to give information about my Medical Assistance eligibility and the information on this form to its representatives, the county where I live and HealthPartners.
The information in this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized by State law to complete this enrollment form on my behalf and 2) I will provide documentation of this authority upon request by the State or HealthPartners.

_____
Name of Applicant (Please print)

_____ _____
Signature Today's Date

If you are the authorized representative, **you must sign above** and provide the following information.

_____ _____
Name (Print) Relationship to Enrollee

_____ _____
Address (Print) Telephone Number

Attention. If you need free help interpreting this document, call 952-967-7998 or 1-866-885-8880.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم 952-967-7998 أو 1-866-885-8880.

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅតាមទូរស័ព្ទមកលេខ 952-967-7998 ឬ 1-866-885-8880 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite 952-967-7998 ili 1-866-885-8880.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau 952-967-7998 los sis 1-866-885-8880.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ 952-967-7998 ຫຼື 1-866-885-8880.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsi bilbiltu 952-967-7998 ykn 1-866-885-8880.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по телефону 952-967-7998 или 1-866-885-8880.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, wac 952-967-7998 ama 1-866-885-8880.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al 952-967-7998 o al 1-866-885-8880.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số 952-967-7998 hoặc 1-866-885-8880.

LB2-0005 (3-13)

This information is available in other forms to people with disabilities by calling 952-967-7998 (voice) or 1-866-885-8880 (toll free), 952-883-6060 (TTY), 1-800-443-0156 (toll free TTY), 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, hearing carry over), or 1-877-627-3848 (Speech to Speech relay service).

HPCare 2015 LB
HPCare_87629 Approved 01/15/2015

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.