EmblemHealth®

Medicaid Advantage Managed Care Enrollment Form

Required for enrollment in the plan listed below

Last Name		**First Name**	
Sex: ☐ Male ☐ Female	**Date of Birth:** / /	**Social Security No.:**	**Medicaid Client ID No. (CIN)**

HIC Number *(only if different from your Social Security Number):* _____

Other health insurance *(if any):* _____

Medicaid Case Number: _____

I live in _____ **County.**

Medicaid Advantage Plan Choice:

☐ EmblemHealth Dual Eligible (HMO SNP)

The information that I have given in my application is true to the best of my knowledge. I understand enrollment in Medicaid Advantage is voluntary. I have been told the rights and benefits that I will have as a member of Medicaid Advantage, and the conditions of participation. I know that I must be enrolled in the same Health Plan's Medicaid Advantage product to enroll or stay enrolled in Medicaid Advantage. I consent to the release of any medical information about me:

- By my primary care provider (PCP), by any other health care provider, or by the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me, as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to SDOH and other authorized federal, state and local agencies for purposes of administration of the Medicaid and/or Medicare programs; and
- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment or heath care operations.

I also agree that HIV/AIDS, mental health or alcohol and substance abuse information about me may be released, to the extent permitted by law, for as long as I remain enrolled in this Medicaid Advantage plan. I know that I can revoke this consent at any time by notifying the health plan in writing, except that this would not apply to information that has already been released. I understand that other federal, state and local laws may also protect the confidentiality of my personal health information.

Applicant's signature **Date** **Phone Number**

Print Authorized Representative's Name *(if applicable)* **Signature** **Phone Number**

AUTHORIZED PLAN REPRESENTATIVE USE ONLY	
Health Plan Certification: Medicare Advantage Enrollment Completed for CMS Submission	Date:
Print Name:	Signature:

HIP Health Plan of New York (HIP) is a HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company.

H3330_123615 Approved 11/05/2013
EMB_MB_FRM_14843_MCaidAdv 11/13