VERDA
HEALTH PLAN OF ARIZONA

# Scope of Appointment Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary or their authorized representative.

## Medicare Advantage (Part C)

*Please initial below beside the type of product(s) you want the agent to discuss.*

☐ **Medicare Health Maintenance Organization (HMO)** —A Medicare Advantage Plan that must cover all Part A and Part B health care. In most HMOs, you can only go to doctors, specialists, or hospitals in the plan's network except in an emergency.

☐ **Medicare Special Needs Plan (SNP)** —A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in a nursing home, and people who have certain chronic medical conditions.

***By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.*** Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

| Beneficiary or Authorized Representative Signature and Signature Date: | |
|---|---|
| Signature: | Signature Date: |
| **If you are the authorized representative, please sign above and print below:** | |
| Representative's Name: | Your Relationship to the Beneficiary: |

**To be completed by Agent:**

| Agent Name: | Agent Phone: |
|---|---|
| Beneficiary Name: | Beneficiary Phone: |
| Beneficiary Address: | |
| Initial Method of Contact: | |
| **Agent's Signature:** | Date: |
| [Plan Use Only:] | |

Verda Health Plan of Arizona, Inc is an HMO plan with a Medicare contract. Enrollment in Verda Health Plan of Arizona, Inc depends on contract renewal. ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-256-5123. (TTY: 711) ATENCIÓN: Si habla español, los servicios de asistencia lingüística están disponibles sin costo alguno para usted. Llame al 1-888-256-5123(TTY: 711).



*Scope of Appointment documentation is subject to CMS record retention requirements *

VERDA
HEALTH PLAN OF ARIZONA

OMB No. 0938-1378
Expires: 12/31/2026

# Model Individual Enrollment Request Form To Enroll In A Medicare Advantage Plan (Part C)

## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

## When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

## What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

## Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:

**Verda Health Plan of Arizona**
**Attn: Enrollment Dept.**
**P.O. Box 105213**
**Jefferson City, MO 65110**

Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call Verda Health Plan of Arizona at 1-877-933-6767 TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Verda Health Plan de Salud Arizona al 1-877-933-6767/TTY o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

## Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**IMPORTANT**

**Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

VERDA
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P.O. Box 105213
Jefferson City, MO 65110
Enrollment FAX: (714) 845-9841

## Section 1 – All fields on this page are mandatory (unless marked as optional)

**Choose the plan you want to enroll in:**

☐ **Verda Noble Care Plan (HMO) – 001**
$0, per month
Maricopa County

☐ **Verda Noble Chronic Care Plan (HMO C-SNP)-002**
$0, per month
Maricopa County

| First Name: | Last Name: | Middle Initial: |
|---|---|---|

| Date of birth: (MM/DD/YYYY) (__ __/__ __/ ___ ___ ___ __) | Sex: ☐ M ☐ F | Phone Number: (     ) |
|---|---|---|

Permanent Residence Street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

| City: | State: | Zip code: | County: |
|---|---|---|---|

Mailing address, if different from your permanent address (PO Box allowed):

| City: | State: | Zip code: |
|---|---|---|

## Your Medicare Information

Please take your Red, White and Blue Medicare card to complete this section.

•Fill this information as it appears on your Medicare card.

-OR-

•Attached a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card)

______________________________________

Medicare Number: __ __ __ __- __ __ __- __ __ __ __

HOSPITAL (Part A): __ __/ __ __/ __ __ __ __

MEDICAL (Part B): __ __/ __ __/ __ __ __ __

You must have Medicare Part A and Part B to join a Medicare Advantage Plan

## Answer these important questions:

1. Will you have other prescription drug coverage (such as VA, TRICARE) in addition to Verda Health Plan of Arizona? ☐ Yes ☐ No

| Name of other coverage: | Member number for this coverage: | Group number for this coverage: |
|---|---|---|
| ________________________ | ___________________________ | __________________________ |

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If "yes", please provide the following information: Medicaid ID #: _____________________________________

3. Do you have Cardiovascular Disorder, Congestive Heart Failure (CHF) and or Diabetes? ☐ Yes ☐ No
*If yes, please fill out the Pre-Enrollment Qualification Assessment form found towards the end of this booklet.

## Important: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Verda Health Plan of Arizona.
- By joining this Medicare Advantage [or Medicare Prescription Drug] Plan, I acknowledge that Verda Health Plan of Arizona will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA Plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA Plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Verda Health Plan of Arizona coverage begins, I must get all of my medical and prescription drug benefits from Verda Health Plan of Arizona. Benefits and services provided by Verda Health Plan of Arizona and contained in my Verda Health Plan of Arizona "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Verda Health Plan of Arizona will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

| **Signature:** | **Today's Date:** |
|---|---|

**If you are the authorized representative, sign above and fill out these fields:**

Name: ________________________________ Address: ________________________________

Phone Number: ________________________ Relationship to enrollee: ______________________________

## Section 2 – All fields on this page are optional

**Answering these questions is your choice. You cannot be denied coverage because you don't fill them out.**

**Select one if you want us to send you information in a language other than English.**

☐ Spanish

**Select an option below if you want us to send you information in an accessible format:**

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Verda Health Plan of Arizona at 1-888-256-5123 (TTY users should call 711) if you need information in an accessible format or language other than what is listed above. Our office hours are from 8 a.m. – 8 p.m.,7 days a week from October 1 to March 31 and from 8 a.m. – 8 p.m. Monday thru Friday April 1 to Sept 30

| Do you work? ☐ Yes ☐ No | Does your spouse work? ☐ Yes ☐ No |
|---|---|

**Please choose a Primary Care Physician (PCP)*:** ______________________________________________

**PCP IPA/Medical Group Name:** ________________________ **PCP ID #:** ______________________________

**Are you an existing patient?** ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ ANOC

Email address: ________________________________________

## Paying your Plan Premiums

You can pay your monthly premiums (including any late enrollment penalties you currently have or own) by mail every month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.
If you don't select a payment option, you will get a bill each month.

**Please select a premium payment option.**

☐**Get a Bill** ☐**Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**

I get my monthly benefits from: ☐ Social Security ☐ RRD

The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

**If you must pay a Part D Income Related Monthly Adjustment Amount (IRMAA), you must pay this additional amount in addition to your plan premium.** Usually, the amount is deducted from your Social Security benefit, or you may receive a bill from Medicare (or the RRB). DO NOT pay the Part D IRMAA to **Verda Health Plan of Arizona**.

## For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

☐ IEP/ICEP ☐ AEP ☐ OEP ☐ SEP (type) __________

**Name:** ________________________ **Relationship to enrollee:** ___________________________

**Signature:** ______________ **National Producer Number (Agents/Brokers only):** _______________

**Application Receive Date:** ______________

**Proposed Effective Date:** ____________________(Required)

### PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

## Attestation of Eligibility for an Enrollment Period

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Annual Enrollment Period (AEP), October 15 through December 7

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan, or I recently moved, and have new options available to me. I moved on (insert date) ________________________.

☐ I recently was released from incarceration. I was released on (insert date) ____________.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) __________________.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ________________________________________.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ____________________________.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ________________.

☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ________________________.

☐ I recently left a PACE program on (insert date) ____________________________.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ___________________________.

☐ I am leaving employer or union coverage on (insert date) _____________________.

☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date) ________________________.

☐ I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _______________________________.

☐ I have a Chronic Condition that qualifies me for the chronic condition Special Needs Plan. (C-SNP Only)

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

**If none of these statements applies to you or you're not sure, please contact Verda Health Plan of Arizona at 1-877-933-6767, TTY users should call 711 to see if you are eligible to enroll. Our office hours are from 8 a.m. – 8 p.m., 7 days a week from October 1st to March 31st and from 8 a.m.-8 p.m. Monday through Friday from April 1 to September 30**

VERDA
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# Coordination of Care Form (Required for Both Plans)

## Coordination of Care Form

### Member Information

Full Name: ______________________________________________ Date: ______________
*Last* *First* *M.I.*

Date of Birth: ______________________________ Phone: ______________________________

Emergency Contact: ______________________ Phone: __________ Relationship: ______________

Preferred Spoken Language:

☐ English ☐ Spanish ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Tagalog ☐ Vietnamese ☐ Other: ______________

### Primary Care Physician / Medical Group Information

PCP with Verda Health Plan of Arizona: ______________________________________________

Is this the same PCP as prior to enrolling with Verda? YES ☐ NO ** ☐

Medical Group / IPA with Verda Health Plan of Arizona: ______________________________________

Is this the same Medical Group / IPA as prior to enrolling with Verda? YES ☐ NO ** ☐

** If NO, who is the current PCP and/or Medical Group/IPA? ______________________________________

### Continuity Of Care and Services

Please inform us if you have any of the following issues that apply to you, and we will have a Care Coordination Team member contact you to assist with the transition of services.

☐ Immediate Needs – Food, housing, medication affordability, etc.

☐ Currently Hospitalized

☐ Middle of Treatment – Chemotherapy / Dialysis / Home Health, etc.

☐ Planned Surgery in the coming months

☐ Durable Medical Equipment – ☐ Own ☐ Rent **

☐ Continuous Glucose Monitors (such as Dexcom or FreeStyle Libre)

☐ CPAP Machine ☐ Oxygen ☐ Hospital Bed

☐ Diapers ☐ Pressure Mattress ☐ Catheters

** If you rent DME, who is the DME Company? Name: ______________________ Phone: ________________

### Medications

Please provide a list of medications that require Prior Authorization or are not on our formulary. A Care Coordination Team member will contact you to assist with the prescription transition fills.

Medication Name: ______________________________ Dosage: ______________________________

Medication Name ______________________________ Dosage: ______________________________

Medication Name ______________________________ Dosage: ______________________________

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# Pre-Enrollment Qualification Assessment Form

**PLEASE READ (Required for C-SNP Only):** To enroll in the Verda Health Plan of Arizona Chronic Condition Special Needs Plan, we are required to confirm your diagnosis of a qualifying health condition. When this form is completed and submitted along with an enrollment application, you will be enrolled in the Verda Health Plan of Arizona C-SNP Plan. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from our Special Needs Plan.

## Your Information

Full Name: ________________________________________ Date: ______________

*Last* *First* *M.I.*

Gender: ☐ Male ☐ Female DOB: ______________________

## Chronic Condition Questions:

If any of the following are checked, the enrollee pre-qualifies.

Have you ever been told by a physician that you have any of the following conditions:

☐ Diabetes Mellitus (High blood sugar)

☐ Chronic Heart Failure (CHF, fluid in the lungs)

☐ Cardiovascular Disorders – must be one of the following:

- Cardiac Arrhythmias (heart rhythm problem)
- Coronary Artery Disease (blocked arteries of the heart, stents in the heart)
- Peripheral Vascular Disease (blocked arteries of the legs)
- Chronic Venous Thromboembolic Disorder (blood clots in the legs or lungs)

## Additional Questions

1. Do you take any medications for the conditions listed above? ☐ Yes ☐ No
2. Are you now or have you ever taken Metformin or Insulin Injection? ☐ Yes ☐ No

**Please check all medications below that you currently take or have previously taken:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Metformin | ☐ Janumet | ☐ Insulin | ☐ Lantus | ☐ Lasix/Furosemide | ☐ Plavix |
| ☐ Glyburide | ☐ Jardiance | ☐ Humulin | ☐ Levemir | ☐ Bumex | ☐ Xarelto |
| ☐ Glipizide | ☐ Tradienta | ☐ Novolin | ☐ Tresiba | ☐ Aldactone | ☐ Eliquis |
| ☐ Actos | ☐ Trijardy | ☐ Novolog | ☐ Ozempic | ☐ Digoxin | ☐ Coumadin |
| ☐ Avandia | ☐ Invokana | ☐ Humalog | ☐ Mounjaro | ☐ Amiodarone | ☐ Nitroglycerin |
| ☐ Farxiga | ☐ Invokamet | ☐ Toujeo | ☐ Trulicity | ☐ Rhythmol | ☐ Ranexa |

**Others:**

| | | |
|---|---|---|
| ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ |

## **REQUIRED** Current Treating Physician

Provider Name: ______________________ Address: ______________________________________

Phone Number: ______________________ Fax Number: ______________________________________

## ** REQUIRED** Current Specialist (If none, write N/A)

Specialist Name: ______________________ Address: ______________________________________

Phone Number: ______________________ Fax Number: ______________________________________

## Disclaimer and Signature

***Authorization for Disclosure of Health Information to verify Chronic Condition(s):***

*I hereby authorize the disclosure of my health information by the provider(s) listed above to Verda Health Plan to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in a Verda Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.*

***Note:*** *Information disclosed because of this authorization will be protected by Verda Health Plan in accordance with applicable state and federal laws and requirements.*

Enrollee Signature: ______________________________________________ Date: ________________