

# CENTRAL HEALTH PLAN

## **Enrollment Application**

Toll Free 1-866-360-1509

Please Print

This is not an insurance plan.

### Your Information

\_\_\_\_\_  
Last name First name Middle initial

\_\_\_\_\_  
Social Security Number Birth Date Sex:  Male  Female

\_\_\_\_\_  
Home Address City State Zip

\_\_\_\_\_  
PO Box or Mailing Address if different than above City State Zip

\_\_\_\_\_  
Home telephone number or cell phone number Work telephone number

Marital status:  Single  Married  Separated  Divorced  Widowed

Race (optional):  African American  Caucasian  Hispanic  Asian  American Indian  Other

Are you a U.S. Citizen?  Yes  No

### Your Medical Coverage

Do you have Medicaid coverage?  Yes  No If Yes, is it Spend-down Coverage?  Yes  No

Do you have Medicare coverage?  Yes  No If Yes, when did your Medicare coverage start? \_\_\_\_\_

Do you have any OTHER medical coverage?  Yes  No If YES, what kind? \_\_\_\_\_

When did coverage start? \_\_\_\_\_ Do you have medical benefits through V.A.?  Yes  No

### Your family size

Do you have children living with you who are under 18 or are your legal dependents?  Yes  No

How many? \_\_\_\_\_ What is your household size? (You + your spouse + your dependent children) \_\_\_\_\_

### Your Doctor

Do you already have a Primary Care Provider?  Yes  No, Who? \_\_\_\_\_

If no, we will automatically assign you to a participating Primary Care Provider in your area.

### Your Income

**Total monthly income, before taxes: (Do not include income from dependent children)**

\$ \_\_\_\_\_ You need to provide us copies of your latest month's worth of paycheck stubs and/or unemployment award letter (a copy of your bank statement showing the deposit) for you and your spouse.

**\*\*\*You must read and sign the backside of this consent form to be eligible for the plan.**

## **Notice to Enrollees of the Central Health Plan**

Unless you are qualified for the Adult Benefit Waiver and have enrolled for the Adult Benefit Waiver through the Department of Human Services, enrollment in and eligibility for the Central Health Plan is based solely upon criteria established by the Central Health Plan. Enrollment with the Central Health Plan does not establish or confer any contractual rights to you as an enrollee with the Central Health Plan.

The Central Health Plan may change its enrollment criteria for enrollment with the Central Health Plan at any time without prior notice to you. A change in the Central Health Plan's enrollment criteria may result in your disenrollment from the Central Health Plan and the termination of benefits you received as an enrollee in the Central Health Plan. Prior to termination of those benefits, the Central Health Plan will notify you of the scheduled termination of benefits at the address you have provided to the Central Health Plan.

Health benefits available to enrollees with the Central Health Plan must be performed, prescribed, directed or authorized by health care providers who are part of the Central Health Plan's network. Unauthorized services received from other health care providers will not be covered. Any covered health care service, other than emergency services, that is not provided by your assigned primary care provider must be authorized by your primary care provider prior to the delivery of the covered health care service. You may be liable for the costs of health care services that are not properly authorized.

The health benefits offered to enrollees in the Central Health Plan are limited. The Central Health Plan is not insurance or an HMO plan, but is a limited program of health benefits delivered only by health care providers participating in the Central Health Plan network.

### **Verification of Eligibility**

I certify that the information on this application is true, complete, and accurate to the best of my knowledge, and I understand that misrepresentation of the facts may mean that my enrollment in the Central Health Plan will be discontinued. If insurance becomes available to me or if my income changes to make me ineligible to be an enrollee in the program, I will notify Central Health Plan to discontinue my enrollment.

### **Release of Information**

I authorize the Central Health Plan to obtain information from this application and my medical records for use by the Central Health Plan and its program administrator for eligibility verification, enrollment, claims payment, program notifications, regulatory compliance, reimbursement and other program administration purposes, including quality of care evaluations, as may be required. This authorization includes all my medical records, including records of mental health and substance abuse services, diagnostic and treatment records related to HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), AIDS Related Complex (ARC), venereal disease, tuberculosis and hepatitis. I understand that this specific authorization is needed because Federal and/or State regulations provide for confidentiality of that information. This authorization for release shall be effective for five (5) years from the date of this consent. I understand that I can cancel this authorization for release at any time by filing a letter with the Central Health Plan and it will be effective on the date of my written request and for any time thereafter. The Central Health Plan may still use information collected prior to the date of my written request.

I have read and understand this consent and have had any questions related to this consent answered, and agree by signing below.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date