HealthPartners® Inspire (SNBC) Enrollment Form

HealthPartners Enrollment Telephone Numbers
952-967-7264 or 888-347-7264. TTY for the hearing impaired at 711.
Monday through Friday, 8 a.m. to 6 p.m. CT
The call is free.

HealthPartners Member Services Telephone Numbers
952-967-7998 or 866-885-8880. TTY for the hearing impaired at 711.
Monday through Friday, 8 a.m. to 6 p.m. CT
The call is free.

You can speak to someone about getting this information for free in other languages.
Call 952-967-7998 or 866-885-8880. TTY users should call 711.
Monday through Friday, 8 a.m. to 6 p.m. CT
The call is free.

Return the completed form, pages 2 to 3, to:

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

Fax number: 952-853-8746

HealthPartners®

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

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Last name	First name	MI (optional)	Birth date (___/___/_____) MM/DD/YYYY	Gender □ M □ F

County you live in	Phone number (_____) _____-_____	Optional: Another phone number (_____) _____-_____

Street address (where you live)	City	State	Zip code
Mailing address (if different from where you live)	City	State	Zip code

Email address (optional)

Medical Assistance ID number (PMI)	Case number

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)

□ Amharic (09) □ Arabic (10) □ Oromo (12) □ Burmese (14)

□ Cantonese (15) □ French (16) □ Korean (20) □ Karen (21)

□ (98) Other, explain: _____

Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? □ YES □ NO

Do you have Medicare coverage? □ YES □ NO If Yes, complete the information below

Medicare number:

Hospital (Part A) Begin Date: Medical (Part B) Begin Date:

Do you have *other* medical coverage or private insurance?

□ YES □ NO

If Yes, insurance company name: _____

Policyholder's name: _____ Group number: _____

Policy/ID number: _____ Is this insurance through an employer? □ YES □ NO

YOU ARE CHOOSING HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to change back to Medical Assistance fee-for-service effective the 1st of the next month.

Please read and sign page 3 of this form

Under HealthPartners® Inspire (SNBC), I understand that:

HealthPartners® Inspire will be providing my health care covered by Medical Assistance.
Once I am a member of HealthPartners® Inspire, I have the right to appeal any services that are being denied, reduced, or stopped, or if HealthPartners® Inspire is denying payment for services.
I will be notified of the date my coverage will start.
On the date HealthPartners® Inspire coverage begins, I must get my health care from HealthPartners® Inspire doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get HealthPartners® Inspire approval to see other providers in some circumstances.
I will read the Member Handbook from HealthPartners® Inspire. It will have the rules I must follow and more information about the services my plan covers. Services contained in HealthPartners® Inspire's Member Handbook will be covered.
Some services require authorization from HealthPartners® Inspire. Without authorization, HealthPartners® Inspire will not pay for these services.
My HealthPartners® Inspire benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave HealthPartners® Inspire and change back to Medical Assistance fee-for-service. The effective date depends upon the date your request is received. I understand that I will be enrolled in HealthPartners® Inspire through the last day of the month.
My health care services will be coordinated through HealthPartners® Inspire.
To be enrolled and stay enrolled in HealthPartners® Inspire, I must: • Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) • Be at least 18 years old and under 65 years old • Be eligible for health care through Medical Assistance without a medical spenddown • Either have no Medicare, **OR** have **both** Medicare Parts A **and** B • Live in a county serviced by HealthPartners® Inspire If this changes, I will notify my county worker and HealthPartners® Inspire so my information can be updated.
If I get a medical spenddown while enrolled in SNBC and **do not pay it to DHS**, I will be disenrolled from HealthPartners® Inspire.
If I am on Medical Assistance for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance.

By enrolling in HealthPartners® Inspire, I authorize:

The sharing of information about my Medical Assistance eligibility status and the information on this form among the state, its representatives, the county where I live, and HealthPartners® Inspire.
The information on 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 form means that I have read and understand the contents of the form. 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) documentation of this authority is available upon request by the state or HealthPartners® Inspire.

Signature of enrollee or authorized representative:		Date:
If you are the authorized representative, you must sign above and provide the following information		
Name (print):	Relationship to enrollee:	Phone number:
Street address, city, state, zip code:		

Page 3 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax it to HealthPartners.
Our address and fax number are on the cover.