Hennepin Health

Hennepin Health SNBC Enrollment Form

Hennepin Health SNBC Enrollment Telephone Numbers
Hennepin Health–SNBC Member Services Telephone Numbers
612-596-1036 or 1-800-647-0550. TTY for the hearing impaired at 1-800-627-3529. Monday – Friday, 8:00 a.m. – 4:30 p.m. The call is free.

Hennepin Health SNBC Member Services Telephone Numbers
612-596-1036 or 1-800-647-0550. TTY for the hearing impaired at 1-800-627-3529. Monday – Friday, 8:00 a.m. – 4:30 p.m. You can speak to someone about getting this information for free in other languages. Call 612-596-1036 or 1-800-647-0550. TTY/TDD users should call 1-800-627-3529, Monday – Friday, 8:00 a.m. – 4:30 p.m. The call is free.

Return the completed form, pages 2, 3 and 4, to:

Hennepin Health SNBC Enrollment
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415

Or

Fax: 612-632-8618

For accessible formats of this publication or assistance with additional equal access to our services, write to hennepinhealth@hennepin.us, call 612-596-1036 use your preferred relay service.

DHS approved 11/2/2020
MA-1120-MC

HENNEPIN HEALTH SPECIAL NEEDS BASICCARE ENROLLMENT FORM

Last name	First name	MI (optional)	Birth date (___/___/_____) MM/DD/YYYY	Gender ❑ M ❑ F
County you live in	Social Security number (optional)	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	Are you pregnant? ❑ YES ❑ NO		

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) ❑ Other (98), explain _____

Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT) or are you enrolled in the Developmental Disability waiver? ❑ 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 live in a long-term facility? ❑ YES ❑ NO If Yes, fill in the information below:

Name of the facility: Phone number: (_____) _____ - _____

Some individuals may have other medical coverage, including other private insurance.

Do you have other medical coverage? ❑ YES ❑ NO

If Yes, insurance company name: _____

Policyholder's name: _____ Group number: _____

Policy/ID number: _____

Is this insurance through an employer? ❑ YES ❑ NO

CHOOSE HOW YOU WILL GET YOUR HEALTH CARE COVERAGE

Remember, joining SNBC is voluntary. You can always request to drop out and change back to Medical Assistance (Medicaid) fee-for-service effective the next available month.

Primary care clinic you are choosing	Primary care clinic (PCC) number

Please read and sign the back of this form
Under *Hennepin Health SNBC*, I understand that:

Hennepin Health SNBC will be providing my health care covered by Medical Assistance (Medicaid).
Once I am a member of **Hennepin Health SNBC**, I have the right to appeal any services that are being denied, reduced, or stopped, or if **Hennepin Health SNBC** is denying payment for services.
I will be notified of the date my coverage will start.
On the date **Hennepin Health SNBC** coverage begins, I must get my health care from **Hennepin Health SNBC** doctors and other providers, except for emergency or urgently needed care, open access services, out-of-area dialysis, or if I get **Hennepin Health SNBC** approval to see other providers in some circumstances.
I will read the Member Handbook from **Hennepin Health SNBC**. It will have the rules I must follow and more information about the services my plan covers. Services contained in **Hennepin Health SNBC's** Member Handbook will be covered.
Some services require authorization from **Hennepin Health SNBC**. Without authorization, **Hennepin Health SNBC** will not pay for these services.
My **Hennepin Health SNBC** benefits **cannot** be canceled because I get sick or use health care services.
I can choose to leave **Hennepin Health SNBC** and change back to Medical Assistance (Medicaid) fee-for-service, effective the following month. I understand that I will be enrolled in **Hennepin Health SNBC** through the last day of the month.
My health care services will be coordinated through **Hennepin Health SNBC**.

To be enrolled and stay enrolled in **Hennepin Health SNBC**, I must:

- Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) or be enrolled in the Developmental Disability waiver
- Be at least 18 years old and under 65 years old
- Be eligible for Medical Assistance (Medicaid) without a medical spenddown
- Either have no Medicare, **OR** have **both** Medicare Parts A **and** B
- Live in a county serviced by **Hennepin Health SNBC**

If this changes, I will notify my county worker and **Hennepin Health SNBC** so I can disenroll.

If I get a medical spenddown while enrolled in SNBC and **do not pay it to DHS**, I will be disenrolled from Hennepin Health SNBC.

If I am on Medical Assistance (Medicaid) for Employed Persons with Disabilities (MA-EPD), I must continue to pay my MA-EPD premium to remain eligible for Medical Assistance (Medicaid).

By enrolling in Hennepin Health SNBC, I authorize:

The sharing of information about my Medical Assistance (Medicaid) eligibility status and the information on this form among the state, its representatives, the county where I live, and **Hennepin Health SNBC**.

The information on this enrollment form is correct to the best of my knowledge.

I understand that my signature (or the signature of 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 Hennepin Health SNBC.

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		

Page 4 should be signed and filled out by you or your authorized representative.

When the form is completed, mail or fax pages 2, 3, and 4 to Hennepin Health SNBC.
Return the completed form to:

Hennepin Health SNBC
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415
Or
Fax: 612-632-8618