



# 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® Inspire (SNBC) Enrollment Form

Last name	First name	MI (optional)	Birth date (____/____/____) MM/DD/YYYY	Gender <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If Yes, check one of the boxes below				
<input type="checkbox"/> Spanish (01) <input type="checkbox"/> Hmong (02) <input type="checkbox"/> Vietnamese (03) <input type="checkbox"/> Khmer (Cambodian) (04) <input type="checkbox"/> Lao (05) <input type="checkbox"/> Russian (06) <input type="checkbox"/> Somali (07) <input type="checkbox"/> ASL (American Sign Language 08) <input type="checkbox"/> Amharic (09) <input type="checkbox"/> Arabic (10) <input type="checkbox"/> Oromo (12) <input type="checkbox"/> Burmese (14) <input type="checkbox"/> Cantonese (15) <input type="checkbox"/> French (16) <input type="checkbox"/> Korean (20) <input type="checkbox"/> Karen (21) <input type="checkbox"/> (98) Other, explain: _____				
Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Do you have Medicare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO    If Yes, complete the information below				
Medicare number: _____				
Hospital (Part A) Begin Date: _____		Medical (Part B) Begin Date: _____		
Do you have <i>other</i> medical coverage or private insurance?				
<input type="checkbox"/> YES <input type="checkbox"/> NO				
If Yes, insurance company name: _____				
Policyholder's name: _____		Group number: _____		
Policy/ID number: _____		Is this insurance through an employer? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>YOU ARE CHOOSING HOW YOU WILL GET YOUR HEALTH CARE COVERAGE</b>				
Remember, joining SNBC is voluntary. You can always request to change back to Medical Assistance fee-for-service effective the 1 <sup>st</sup> 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 <b>cannot</b> 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: <ul style="list-style-type: none"><li>• Be certified disabled by the Social Security Administration or State Medical Review Team (SMRT)</li><li>• Be at least 18 years old and under 65 years old</li><li>• Be eligible for health care through Medical Assistance without a medical spenddown</li><li>• Either have no Medicare, <b>OR</b> have <b>both</b> Medicare Parts A <b>and</b> B</li><li>• Live in a county serviced by HealthPartners® Inspire</li></ul>
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 <b>do not pay it to DHS</b> , 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:	
<b>If you are the authorized representative, you must sign above and provide the following information</b>		
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.**