SCAN Medi-Cal Services

Application and Statement of Understanding

Effective Date	Birthdate / /	☐ Male ☐ Female

Beneficiary Name: Last	First	M.I.

Home Address	Apt.#

City	State	Zip Code

County	Telephone ( )

Medi-Cal Information

Please write your Medi-Cal ID Number														
Issue Date			/			/								
	M	M		D	D		Y	Y	Y	Y				

I authorize the county of my residence to release information regarding my Medi-Cal status to SCAN Health Plan, County, State or Federal staff, whose job requires access to this information for the purpose of determining or maintaining my eligibility for SCAN coverage. I understand I am not legally required to authorize this release but that my failure to do so will make me ineligible for the SCAN Medicare/Medi-Cal Plan. I understand this authorization will expire one year from the date of my signature. I hereby enroll in SCAN Health Plan, so that SCAN may administer my Medi-Cal benefits, and in doing so I may receive health care services through SCAN. I understand that my Medi-Cal will be assigned to SCAN unless I lose Medi-Cal eligibility or disenroll voluntarily, and that it can take the Department of Health Care Services 15–45 days to officially disenroll my Medi-Cal from SCAN Health Plan.

ID Number

STATE OF CALIFORNIA
BENEFITS IDENTIFICATION CARD
ID No. 01234567A96144
JOHN Q RECIPIENT
M 05 20 1991 Issue Date 05 24 16
SAMPLE

Birthdate Issue Date

FOR OFFICE USE ONLY				
	County Code		Aid Code	

Are you currently enrolled in any of the following programs?	
1. Nursing Facility Acute Hospital (NF/AH) Waiver?	☐ Yes ☐ No
2. Multipurpose Senior Services Program (MSSP)?	☐ Yes ☐ No
3. In-Home Operations (IHO)?	☐ Yes ☐ No
4. Assisted Living Waiver Pilot Project (ALWPP)?	☐ Yes ☐ No
5. In-Home Supportive Services (IHSS)?	☐ Yes ☐ No

Per State requirements, if you are enrolled in any one of the programs listed above, you must first disenroll from any of these programs before you can enroll your Medi-Cal with SCAN Health Plan.

Important Information — Please read the following:

1. I know that I must disenroll my Medi-Cal from SCAN Health Plan if I choose to receive services from any of the programs listed above.
2. The person who enrolled me, gave me his/her name, showed me his/her SCAN ID badge and said he/she is a representative of SCAN Health Plan.
3. 1) I have received information on SCAN benefits.
   2) I understand **I am to use only SCAN contracted providers.** I cannot use my current doctor once I am enrolled in SCAN unless he/she is contracted with SCAN Health Plan.
4. Enrollment is not effective until processing is completed.
5. If I am currently a beneficiary of another HMO, I am to **continue receiving medical care from my current HMO until my confirmed enrollment date with SCAN.**
6. I will receive instructions from SCAN on how I can obtain a physical or electronic copy of the Evidence of Coverage no later than 7 days after the effective date of enrollment.
7. If I move out of the service area I will need to notify SCAN so I can be disenrolled. SCAN's service area is the list of approved counties provided in the Evidence of Coverage.
8. I may contact the Personal Assistance Line (PAL) any time I have a problem or complaint about the services I receive from SCAN Health Plan at 1-866-722-6725 (1-866-SCAN-PAL) or TTY users: 711, 8 A.M. to 8 P.M., 7 days a week, from October 1 to March 31; and 8 A.M. to 8 P.M., Monday thru Friday, from April 1 to September 30.
9. SCAN will be sending a questionnaire to my home to accurately assess my needs. All information will be treated confidentially and no names will be used in reports.
10. As long as I am enrolled in Medi-Cal I may disenroll from SCAN once per calendar quarter during the first nine months of the year. I may call and request a disenrollment form be mailed to me. I do not have to appear in person to disenroll. There may be other times disenrollment can take place based on certain circumstances.
11. I was given a copy of the Receipt of Application form by the SCAN Representative.

Signature

I acknowledge that my signature on this Application and Statement of Understanding means that I have read and understand the contents of this application in its entirety. If signed by an authorized representative, 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 from Medicare.

Signature: ______________________________ Date: ______________

If you are the authorized representative, you must sign above and provide the following information:

Name: ______________________________

Address: ______________________________

Home Phone Number: ____________________ Relationship to Enrollee: ______________

OFFICE USE ONLY	NAME OF STAFF MEMBER (if assisted in enrollment)		REP. CODE
EFFECTIVE DATE OF COVERAGE / /		ICEP/IEP:____ SEP (type): ____	AEP: ____ Not Eligible: ____

SCAN Health Plan is an HMO plan with a Medicare contract and a contract with the California Medicaid (Medi-Cal) program. Enrollment in SCAN Health Plan depends on contract renewal.