

ExpressLine

Agent-Assisted Telephone Enrollment System Checklist

Please refer to this handy checklist prior to using the telephone enrollment system. By using this form you can help to ensure smoother, more accurate enrollments.

When providing the enrollee's demographic information to the customer service representative, speak slowly and clearly. Spell things out whenever possible, to avoid errors.

Core questions (appear on every product's application)

<p><input type="checkbox"/> Plan Selection _____</p> <p><input type="checkbox"/> Last Name _____</p> <p><input type="checkbox"/> First Name _____</p> <p><input type="checkbox"/> Middle Initial _____</p> <p><input type="checkbox"/> Suffix _____</p> <p><input type="checkbox"/> Medicare Claim Number _____</p> <p><input type="checkbox"/> Part A Effective Date _____</p> <p><input type="checkbox"/> Part B Effective Date _____</p> <p><input type="checkbox"/> Birth Date _____</p> <p><input type="checkbox"/> Gender Male Female (Circle one)</p> <p><input type="checkbox"/> Primary Phone Number _____</p> <p><input type="checkbox"/> Permanent Street Address _____</p> <p><input type="checkbox"/> Street Number _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Street Name _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Apartment Number _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> County _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> City _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> State _____</p> <p style="padding-left: 20px;"><input type="checkbox"/> Zip Code _____</p>	<p><input type="checkbox"/> Mailing Address</p> <p><input type="checkbox"/> Same as permanent address? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Street Number _____</p> <p><input type="checkbox"/> Street Name or PO Box number _____</p> <p>_____</p> <p><input type="checkbox"/> Apartment Number _____</p> <p><input type="checkbox"/> County _____</p> <p><input type="checkbox"/> City _____</p> <p><input type="checkbox"/> State _____</p> <p><input type="checkbox"/> Zip Code _____</p> <p><input type="checkbox"/> Email Address</p> <p><input type="checkbox"/> Is applicant a resident in a long-term care facility?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Name of facility _____</p> <p>_____</p> <p><input type="checkbox"/> Phone number of facility _____</p> <p>_____</p> <p><input type="checkbox"/> Would applicant prefer information in Spanish?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Include phone number to call for information in other formats or languages</p> <p>_____</p> <p><input type="checkbox"/> Discussed upcoming verification call _____</p> <p>_____</p>
--	---

1-800-867-4347

Daily 8:00 a.m. – 8:00 p.m. and
Sunday Noon – 5:00 p.m.

Community CCRx and PrescribaRx Only

Other drug coverage (private insurance, TRICARE, Federal employee health benefits, VA benefits, or state pharmaceutical assistance programs)

Name of coverage _____

ID# for coverage _____

Group# for coverage _____

Enrollment period

AEP _____

IEP _____

SEP-list choices _____

PFFS, PPO and HMO Only

Does applicant have end-stage renal disease? Yes No

Is applicant enrolled in Medicaid? Yes No

If yes, provide Medicaid number _____

Is applicant (or spouse) employed? Yes No

If applying for an MA-PD plan:

Does applicant have other drug coverage (private insurance, TRICARE, Federal employee health benefits, VA benefits, or state pharmaceutical assistance programs). Yes No

If yes, list the following

Name of coverage _____

ID# for coverage _____

Group # for coverage _____

Enrollment period

AEP _____

OEP _____

ICEP _____

IEP _____

SEP-list choices _____

PPO and HMO Only

Primary Care Physician selection

Physician Name _____

Address _____

City _____

State _____

Zip Code _____

Is applicant currently a patient of this physician? Yes No _____