FAX TRANSMITTAL

Date:_____/_____/_____ **No. of pages including cover sheet:** _____

To: Corporate Medicare Enrollment _____ **Fax #**: 1-844-222-3180 **Enrollee name:** _____ **Application signature date**:____/___/**2018**	**From**: Sales Channel Name: _____ **Fax #:** _____ **Phone#:** _____ **Email address:** _____@ _____ **Market**: ☐ AR ☐ AZ ☐ FL ☐ GA ☐ IL ☐ IN ☐ KS ☐ LA ☐ MO ☐ MS ☐ NM ☐ OH ☐ OR ☐ PA ☐ SC ☐ TX ☐ WA ☐ WI

Application *(check all that are complete):*

☐ Submitted within 24 hours of enrollee signature date

☐ Medicare Claim Number (HIC Number)

Questions: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Page 3: ☐ PCP Name and NPI Number

Page 5: ☐ Signature and date ☐ Plan ID# ☐ Effective Date of Coverage ☐ SEP Type (DE)

Scope of Appointment *(check all that are complete):*

☐ Initials ☐ Signature ☐ Date ☐ Agent's Information ☐ Initial method of contact

Appointment of Representative (HIPAA) Form:

☐ All required information is completely filled out, including the required signature and dates.

New Member Medical Care Checklist (NMMC):

☐ NMMC completed (medical information included) and mailed to the health plan.

☐ NMMC NOT completed (no medical information to report).

Notes:

Make sure that you keep the fax/ scan confirmation sheet as proof the application is received at the Enrollment Department