



FAX TRANSMITTAL

Date: ____/____/____

No. of pages including cover sheet: _____

<p>To: Corporate Medicare Enrollment</p> <hr/> <p>Fax #: 1-844-222-3180</p> <p>Enrollee name:</p> <hr/> <p>Application signature date: ____/____/2018</p>	<p>From: Sales Channel Name: _____</p> <p>Fax #: _____</p> <p>Phone#: _____</p> <p>Email address: _____ @ _____</p> <p>Market: <input type="checkbox"/> AR <input type="checkbox"/> AZ <input type="checkbox"/> FL <input type="checkbox"/> GA <input type="checkbox"/> IL <input type="checkbox"/> IN <input type="checkbox"/> KS <input type="checkbox"/> LA <input type="checkbox"/> MO <input type="checkbox"/> MS <input type="checkbox"/> NM <input type="checkbox"/> OH <input type="checkbox"/> OR <input type="checkbox"/> PA <input type="checkbox"/> SC <input type="checkbox"/> TX <input type="checkbox"/> WA <input type="checkbox"/> WI</p>
<p>Application (check all that are complete):</p> <p><input type="checkbox"/> Submitted within 24 hours of enrollee signature date</p> <p><input type="checkbox"/> Medicare Claim Number (HIC Number)</p> <p>Questions: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Page 3: <input type="checkbox"/> PCP Name and NPI Number</p> <p>Page 5: <input type="checkbox"/> Signature and date <input type="checkbox"/> Plan ID# <input type="checkbox"/> Effective Date of Coverage <input type="checkbox"/> SEP Type (DE)</p>	
<p>Scope of Appointment (check all that are complete):</p> <p><input type="checkbox"/> Initials <input type="checkbox"/> Signature <input type="checkbox"/> Date <input type="checkbox"/> Agent's Information <input type="checkbox"/> Initial method of contact</p>	
<p>Appointment of Representative (HIPAA) Form:</p> <p><input type="checkbox"/> All required information is completely filled out, including the required signature and dates.</p>	
<p>New Member Medical Care Checklist (NMMC):</p> <p><input type="checkbox"/> NMMC completed (medical information included) and mailed to the health plan.</p> <p><input type="checkbox"/> NMMC NOT completed (no medical information to report).</p>	
<p>Notes:</p>	
<p align="center"><i>Make sure that you keep the fax/ scan confirmation sheet as proof the application is received at the Enrollment Department</i></p>	

The information contained in this fax message is intended only for the personal and confidential use of the designated recipient(s) named above. This message may contain information that is privileged, or is legally privileged, as attorney-client communication and such is confidential, and protected to the fullest extent of the law. If the reader of this message is not the intended recipient, or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error, and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please notify us by faxing us at 1-877-941-1931 or mail us at 7700 Forsyth Blvd, Clayton, MO, 63105 Attn: Enrollment Dept. Thank you.