

AgeRight Advantage Enrollment Receipt



To be completed if enrolling in-person with a Plan Representative.

Please keep this as a record of your completed application to join KeyCare Advantage. This receipt is not a guarantee of enrollment. If your membership is approved, you will receive letters and ID cards to your specified address.

Applicant Name

Proposed Effective Date

Current Plan Name

This Plan listed above will be replaced by KeyCare Advantage on the Proposed Effective Date

Yes or No

Enrollment Confirmation Number

Low Income Subsidy Level (as defined by CMS)

Medicaid Status

*If you lack a Low Income Subsidy, Medicaid, or another cost-lowering program, you are responsible for all cost-sharing amounts on KeyCare Advantage. An overview of the plan costs are located in the Summary of Benefits.

Prescription List

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

Rx Name: _____ Dosage: _____ Qty: ____ Frequency: _____

AgeRight Advantage Enrollment Receipt Continued



Appointment Checklist

The following information was reviewed and explained to the client on the date below. Any and all questions were answered prior to the end of the appointment.

- Plan Type – *Reviewed what type of plan this is*
- Network – *Reviewed plan network (doctors, specialists, providers, etc.)*
- Prescription Drug Coverage
- Star Ratings
- Costs/Coverage – *Premium, max out-of-pocket, copayments, co-insurance*

All plan materials and contact information for the plan and the agent are being left for the client to reference after the date below. This form does not obligate you to enroll into a plan, affect your current enrolment, or enroll you in a Medicare plan.

Call your Plan Representative if you have any questions:

Name: _____

Phone Number: _____

Plan Number and PBP: _____

RxBin: _____

Rx PCN: _____

RxGRP: _____

Today's Date: _____

Confirmation of receipt:

(Patient signature)