



# Portability Managed Care Enrollment Application

Please complete both sides of this form and sign on the back. Please type or print legibly in dark blue or black ink.

Mail completed application to:

ODS  
Attn: Eligibility Department  
601 S.W. Second Ave.,  
Portland, OR 97204

*Applicant name (first, middle initial, last)		*Birth date	*Gender	*Applicant Social Security no.
*Applicant mailing address	*City	*State	*ZIP	Home telephone no.
*E-mail address			*Primary language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Primary care physician (PCP) name and city				

**\*Coverage:**

Managed Care Prevailing Plan

Managed Care Low-cost Plan

\* Enrollment will be delayed if fields noted with an asterisk are not filled out.

## Dependent information (Please list below any dependents for whom you would like to keep coverage and those dependents whose coverage should be terminated.)

Keep	Term	*Name (first, middle initial, last)	*Birth date	*Gender	*Relationship	*Social Security no.	*PCP name (first and last) and city
				<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Spouse <input type="checkbox"/> RDP ♦		
				<input type="checkbox"/> Female <input type="checkbox"/> Male	Child		
				<input type="checkbox"/> Female <input type="checkbox"/> Male	Child		
				<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Child <input type="checkbox"/> Ward		

♦ Relationship code RDP = Registered Domestic Partner

## Other insurance (Coordination of benefits)

Will applicant or any dependents have <b>other</b> insurance?	<input type="checkbox"/> Dental	<input type="checkbox"/> No other dental insurance	<input type="checkbox"/> Medical	<input type="checkbox"/> No other medical insurance	<input type="checkbox"/> Medicare eligible
If yes, list other insurance and ID no.:					

# ODS Portability Managed Care Enrollment Application *It is very important that you sign and date below.*

## Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.\* Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

\* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

**REQUIRED**

*I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all the fields marked with an asterisk are not filled out entirely.*

\*Signature \_\_\_\_\_

\*Date: \_\_\_\_\_

## Portability billing information

You must return the correct premium payment with the portability application. To calculate your correct amount, please refer to the enclosed brochure.

If your group coverage has already ended, you must include payment from the first day of the month following termination of your group coverage.

### Please indicate your preferred billing option:

**MONTHLY ELECTRONIC FUNDS TRANSFER** *(By personal checking account deduction only)*  
(If you select this option, please attach a voided personal check along with a personal check for the first month's premium amount. If your group coverage was terminated within the last 63 days, you must also include payment for any prior month's premium amount. You must complete the electronic deduction authorization below.)

**MONTHLY BILLING STATEMENT** *(Attach a personal check for the correct premium)*

*Please make checks payable to ODS Health Plans, Inc.*

## AUTHORIZATION AGREEMENT FOR ELECTRONIC DEDUCTION

### Instructions:

1. Complete and sign the Authorization Agreement for monthly automatic bank deduction of insurance premium
2. Attach a "VOID" sample of your personal check, in addition to a personal check for your first month's premium amount.
3. Submit the completed application and appropriate documents with your application.

Name of applicant: \_\_\_\_\_ Name of account holder: \_\_\_\_\_

I (or we if this is a joint account) authorize ODS to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of bank: \_\_\_\_\_

Signature of account holder: \_\_\_\_\_ Date: \_\_\_\_\_

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

\* Sending in a check does not guarantee coverage. Your premium payment will not be credited to your account until your application for Portability health insurance coverage has been approved by ODS. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the 1st day of the month after termination of your group coverage. If your application is not approved, you will be notified in writing, and your check will be returned to you.