OMB No. 0938-1378 Expires:7/31/2024

Enrollment Request Form

An Independent Licensee of the Blue Cross Blue Shield Association

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Blue Cross Blue Shield of Arizona
P.O. Box 29234
Phoenix, AZ 85038

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Blue Cross® Blue Shield® of Arizona (BCBSAZ) at **1-888-274-0367**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users can call **1-877-486-2048.**

En español: Llame a Blue Cross® Blue Shield® of Arizona (BCBSAZ) al **1-888-274-0367, TTY: 711** o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Medicare Advantage (PPO)

Service area: Maricopa County and Pima County Individual Enrollment Instructions

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please complete the application using a black ballpoint pen.
All sections must be filled out and submitted for enrollment.

Medicare Advantage (PPO)

Service area: Maricopa County and Pima County Individual Enrollment Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Maricopa County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-001)

Pima County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-002)

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare I.D. card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name: Jane L. Smith
(as it appears on your Medicare card)

Medicare Number X X X X - X X X - X X X X

Is Entitled To	Effective Date (MM/DD/YYYY)
HOSPITAL (Part A)	01 / 01 / 2000
MEDICAL (Part B)	01 / 01 / 2000

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

LAST Name: Smith	FIRST Name: Jane	Middle Initial: L.	☐ Mr. ☒ Mrs. ☐ Ms.
Birth Date: 06 / 03 / 1933 (MM / DD / YYYY)	Sex: ☐ M ☒ F	Phone Number: (602) 000-0000	
Permanent Residence Street Address (P.O. Box is not allowed): 1234 West Street			Apt. #: 203
City: Phoenix	State: Arizona		ZIP Code: 85000
County: Maricopa	Email Address: jane.smith@yahoo.com		
Mailing Address (only if different from your Permanent Residence Address): P.O. Box 56789			Apt. #:
City: Phoenix	State: Arizona		ZIP Code: 85000
Alternate Contact: Robert Smith	Phone Number: (602)000-0000		Relationship to you: Brother

Have you recently moved into the service area for the plan you selected above? ☐ Yes ☐ No
If yes, Date of Move _____/_____/_____

STEPS:

A. Select the plan you wish to enroll in.

B. Provide your Medicare Insurance Information as it appears on your red, white and blue Medicare I.D. card.

C. Provide all personal information.

D. The person to contact if we are unable to contact you.

E. Provide the name of your Primary Care Provider (PCP). Without this information, your PCP will be automatically assigned for you by the plan.

YOUR CHECK LIST

Please read the instructions and statements carefully. Please use this check list to make sure you've completed all required information.

☐ **A. WHICH PLAN ARE YOU ENROLLING IN?** – Mark an "X" in the box next to the BCBSAZ Medicare plan you wish to enroll in.

☐ **B. MEDICARE NUMBER** – Please print your Medicare Number exactly as it is written on your Medicare Health Insurance Card or your letter from Social Security or the Railroad Retirement Board.

☐ **C. PERSONAL INFORMATION** –

- **Name** – print your name exactly as it appears on your Medicare Health Insurance Card, even if there is an error. Errors need to be corrected with your local Social Security Administration Office. We will be notified of your corrected name by the Centers for Medicare and Medicaid Services (CMS).
- **Permanent Street Address** - should be your current residence, where you presently live (P.O. Box Address is NOT allowed). You must live within the BCBSAZ service area to join this plan.
- **Mailing Address** *(if different from your Permanent Residence)* – an address where you receive your mail.

☐ **D. ALTERNATE CONTACT** – Provide the name of a friend or relative, who does not reside with you, as an alternate contact should we be unable to reach you.

☐ **E. PRIMARY CARE PROVIDER** – Please print the First and Last Name of your Primary Care Provider (PCP). If you do not complete this information, your PCP will be automatically assigned for you by the plan.

IMPORTANT INFORMATION – Read each statement carefully. If there is anything you do not understand, please contact BCBSAZ at the phone number below, during the hours of operations listed below.

SIGNATURE – By signing your enrollment form, you agree to follow the plan rules and have an understanding of your member responsibilities. If you have any questions, please call us. **Sign your name as it is listed on your Medicare Health Insurance Card, and date the form.** Keep the Enrollment Receipt of the enrollment form for your records. In most cases, we will acknowledge the receipt of your application in writing before the effective date. If someone is assisting you in completing this form, please contact BCBSAZ at the telephone numbers listed below for further instructions. If you have a representative that is completing this form on your behalf, your representative must be a Durable General Power of Attorney (DPOA) or court-ordered Legal Guardian to sign this form. Please provide a copy of the paperwork that shows that your representative is your DPOA or Legal Guardian. Lack of proof will not delay the processing of the application.

Mail the Individual Enrollment Form to:

Blue Cross Blue Shield of Arizona
P.O. Box 29234 Phoenix, AZ 85038

Contact us at:

1-888-274-0367, TTY: 711

We are available October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.
(April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m.)
Or, visit our website at **azblue.com/medicare**

Medicare Advantage (PPO)

Service area: Maricopa County and Pima County Individual Enrollment Form

To enroll, please provide all the information requested below.

REQUIRED: Please mark an "X" in the box next to the plan you wish to enroll in:

Maricopa County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-001)

Pima County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-002)

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare I.D. card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name:_____
(as it appears on your Medicare card)

Medicare Number ___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Is Entitled To	Effective Date (MM/DD/YYYY)
HOSPITAL (Part A)	_____/_____/_____
MEDICAL (Part B)	_____/_____/_____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: ___ ___/___ ___/___ ___ ___ ___ (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Phone Number: ( )	
Permanent Residence Street Address (P.O. Box is not allowed):			Apt. #:
City:	State:		ZIP Code:
County:	Email Address:		
Mailing Address (only if different from your Permanent Residence Address):			Apt. #:
City:	State:		ZIP Code:
Alternate Contact:	Phone Number: ( )		Relationship to you:

Have you recently moved into the service area for the plan you selected above? ☐ Yes ☐ No
If yes, Date of Move _____/_____/_____

Enrollee Name: _____ Plan Effective Date: _____

PLEASE READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to BCBSAZ Medicare Prescription Drug Coverage? ☐ Yes ☐ No

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: _____

   ID # for this coverage: _____ Group # for this coverage: _____

   Plan Start Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

   Plan End Date for this coverage: ___ ___ / ___ ___ / ___ ___ ___ ___
   M M / D D / Y Y Y Y

2. Are you enrolled in your State Medicaid (AHCCCS) program? ☐ Yes ☐ No

   If yes, please provide your Medicaid number: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes," please provide the following information:

   Name of Institution: _____

   Phone Number of Institution: _____

   Address (number and street): _____

BCBSAZ offers BlueJourney PPO Medicare Advantage plans. BCBSAZ Advantage, a separate but wholly owned subsidiary of BCBSAZ, offers Blue Best Life Classic and Plus HMO plans.

Enrollee Name: _____ Plan Effective Date: _____

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.

Enrollee Name: _____ Plan Effective Date: _____

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a Government Entity-Declared Disaster or Other Emergency (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact BCBSAZ toll-free at **1-888-274-0367**, TTY: **711** to see if you are eligible to enroll. We are open October 1 - March 31, seven days a week, 8 a.m. to 8 p.m., April 1 - September 30, Monday through Friday, 8 a.m. to 8 p.m. Or, visit **azblue.com/medicare.**

Do you currently have a Medicare Supplement plan? ☐ Yes ☐ No

☐ I understand I am signing up with a Medicare Advantage Plan with a Part D pharmacy plan. I understand I cannot combine a Medicare Supplement or Medigap plan with a Medicare Advantage plan.

All fields in this section are optional		
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.		
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.		
☐ No, not of Hispanic, Latino/a, or Spanish origin	☐ Yes, Mexican, Mexican American, Chicano/a	
☐ Yes, Puerto Rican	☐ Yes, Cuban	
☐ Yes, another Hispanic, Latino/a, or Spanish origin	☐ I choose not to answer.	
What's your race? Select all that apply.		
☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	☐ I choose not to answer.
Select one if you want us to send you information in a language other than English.		
☐ Spanish		
Select one if you want us to send you information in an accessible format.		
☐ Braille	☐ Large print	☐ Audio CD

Enrollee Name: _____ Plan Effective Date: _____

PAYING YOUR PLAN PREMIUM AND/ OR LATE ENROLLMENT PENALTY

You can pay your monthly plan premium and/or any late enrollment penalty that you currently have or may owe, by Electronic Funds Transfer, credit card or by mail. You can also choose to pay your premium and/ or late enrollment penalty by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay BCBSAZ the Part D-IRMAA**.

People with limited incomes may qualify for *Extra Help* to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this *Extra Help*, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for *Extra Help* online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for *Extra Help* with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please select premium/late enrollment penalty payment option below *(if you don't select a payment option, you will get a bill each month):*

☐ Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Bank name: _____ Account type: ☐ Checking ☐ Savings

Bank routing number: _____ Bank account number: _____

☐ Get a monthly bill (You can pay your monthly bill with a check or call us to pay with a credit card)

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, we will send you an invoice until the deductions from Social Security or RRB are approved, which can take 2-3 months. If Social Security or RRB does not approve your request for automatic deduction, we will continue to send you an invoice for your monthly premiums.)

STOP

PLEASE READ THIS IMPORTANT INFORMATION & SIGN BELOW

If you currently have health coverage from an employer or union, joining BCBSAZ could affect your employer or union health benefits. You could lose your employer or union health coverage if you join BCBSAZ. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

1. BCBSAZ is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan (except for supplements) or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (**Example: October 15 – December 7 of every year**), or under certain special circumstances.
2. BCBSAZ serves a specific service area. If I move out of the area that BCBSAZ serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BCBSAZ, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BCBSAZ when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
3. I understand that beginning on the date BCBSAZ coverage begins, I must get all of my healthcare from BCBSAZ, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCBSAZ and other services contained in my BCBSAZ Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BCBSAZ WILL PAY FOR THE SERVICES**.
4. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BCBSAZ, he/she may be paid based on my enrollment in BCBSAZ.

Release of Information: By joining this Medicare health plan, I acknowledge that BCBSAZ will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that BCBSAZ will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: **X**_____ Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Address: _____

Phone Number: (____)_____ Relationship to Enrollee: _____

Office Use Only:

Member ID #: _____ Plan Effective Date: _____ ICEP/IEP: _____ AEP: _____ OEP: _____

SEP: ____ / SEP Reason: _____ Not Eligible: ____ Enrollment Rep: _____ Completed Date: _____

For Use by Agent/Broker:

Certified Agent Name (Print): _____ Agent/Broker #:_____

Broker of Record*: _____ Requested Effective Date: _____

Agent/Broker Signature: _____

Date Received:_____ Phone Number: _____

**Enter the Name of the Entity contracted with BCBSAZ*

Enrollee Name: _____

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

2024 Enrollment Receipt

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment, and you receive your member ID card. **This receipt is not a guarantee of enrollment.**

This copy is for your records only. Please do not resubmit enrollment.

Fill out this plan recap with your Licensed Sales Representative (if applicable). It will take you through some plan details to help you better understand your new plan.

Here are some details about your new plan:

Enrollee Name:	
Application Date:	My plan coverage begins (effective date):

My new plan name is:

Maricopa County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-001)

Pima County

☐ BlueJourney (PPO)
$60 monthly premium (H5140-002)

My plan type is: ☐ PPO	RxBIN: 610011 RxPCN: CTRXMEDD RxGRP: BAZMAPD

Premium Information:
My plan has a: $ _____ monthly premium. I understand I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me.

If I owe a Late Enrollment Penalty (LEP), it is not included in my premium and I will need to add it to my premium each month.

I must live in the plan's service area. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

I can cancel my enrollment in this plan before my coverage starts by calling Member Services at **480-937-0409** (in Arizona) or toll-free at **1-800-446-8331 (TTY users should call 711). We are open October 1 – March 31, seven days a week, 8 a.m. to 8 p.m.; April 1 – September 30, Monday through Friday, 8 a.m. to 8 p.m.** Once my coverage starts, I may have to wait until the Annual Enrollment Period (Oct 15 – Dec 7) to make a plan change, unless I qualify for a Special Election Period.

Call your Licensed Sales Representative if you have any questions:

Licensed Sales Representative Name and ID Number	Licensed Sales Representative Phone No.

This page intentionally left blank

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-446-8331. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-446-8331. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-446-8331。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-446-8331。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-446-8331. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-446-8331. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-446-8331 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-446-8331. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-446-8331 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-446-8331. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-446-8331. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-446-8331 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-446-8331. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-446-8331. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-446-8331. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-446-8331. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-446-8331 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Navajo: T'áá hait'éego da ats'íís baa'áhayą́ doodago azee' aanídaa'niłí nihinaaltsoos bee hadadít'éhígíí bąąh na'ídikid nee hólǫ́ǫgo da nihi éí ata' halne'í bee áka'anída'awo'í t'áá jíík'eh nihee hóló. Ata' halne'í ła' yíníkeedg kohjį' 1-800-446-8331 nihich'į' hodíilnih. T'áá háida Bilagáana Bizaad yee yáłti'ígíí ła' niká'iilyeed dooleeł. Díí t'áá jiik'eh bee niká'iilyeed dooleeł.

Y0137_Y35510PY24_C

NOTES:

NOTES:

An Independent Licensee of the Blue Cross Blue Shield Association

Y0137_ L35224PY24_C CMS Approved 08/23/23

255031023

1316393-23