ATLANTIC DIALYSIS MANAGEMENT SERVICES
FAX (718) 386-4818
EMAIL: HR@atlanticdialysis.com

TPA exchange

ENROLLMENT OF GROUP BENEFITS

PLAN:	**EPO( ) PPO ( )**	**ENROLLMENT** NEW HIRE_____
OFFICE LOCATION:		**CHANGE** ADD SPOUSE_____ DROP SP_____
		ADD DEP_____ DROP DEP _____

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME	MIDDLE IN	DOB (mm/dd/yy)	SOCIAL SECURITY NUMBER

EMPLOYEE MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE

EMPLOYEE PHONE NUMBER	EMPLOYEE EMAIL ADDRESS

BENEFIT COMMUNICATION

WOULD YOU LIKE TO RECEIVE YOUR BENEFIT COMMUNICATION (EOB'S ETC.) VIA EMAIL? ☐ YES ☐ NO

SEX	MARITAL STATUS	DATE EMPLOYED
☐ MALE	☐ MARRIED ☐ SINGLE	
☐ FEMALE	☐ DIVORCED ☐ OTHER	

COVERAGE ELECTED

MEDICAL ___SINGLE ___SPOUSE ___CHILD ___CHILDREN ___FAMILY

DEPENDENTS:

	LAST NAME	FIRST NAME	SEX	DOB (mm/dd/yy)	SOCIAL SECURITY NUMBER
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					

CREDITABLE COVERAGE INFORMATION

DO YOU OR YOUR DEPENDENTS HAVE PREVIOUS CREDITABLE MEDICAL COVERAGE UNDER ANOTHER HEALTH PLAN SUCH AS AN EMPLOYER SPONSORED GROUP HEALTH PLAN OR HMO, INDIVIDUAL POLICY, MEDICARE, MEDICAID OR CHAMPUS? Circle YES - NO

IF YES, A COPY OF ANY CERTIFICATES OF CREDITABLE MEDICAL COVERAGE MAY BE REQUIRED PRIOR TO ANY CLAIMS BEING PROCESSED UNDER THIS PLAN. Circle ☐ CERTIFICATE ATTACHED ☐ CERTIFICATE BEING FORWARDED

OTHER COVERAGE INFORMATION

DO YOU OR ANY COVERED DEPENDENTS HAVE OTHER COVERAGE? Circle YES - NO IF YES, PLEASE PROVIDE POLICY #_____

CARRIER NAME_____EMPLOYER NAME_____EFFECTIVE DATE_____

WHO'S COVERED?_____

EMPLOYEE AUTHORIZATION

I HEREBY REQUEST COVERAGE UNDER THE GROUP POLICY(IES) ISSUED BY MY EMPLOYER'S HEALTH PLAN COVERING CERTAIN EMPLOYEES OF MY EMPLOYER AND AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY EARNINGS ANY REQUIRED CONTRIBUTIONS. I AM AN ELIGIBLE EMPLOYEE WORKING THE REQUIRED HOURS PER WEEK FOR MY EMPLOYER. I UNDERSTAND THAT MY ELECTION OF COVERAGES ABOVE DOES NOT AUTOMATICALLY GUARANTEE THAT COVERAGE IS IN FORCE. ALL ELIGIBILITY REQUIREMENTS OF THE POLICY(IES) MUST BE PROPERLY SATISFIED BEFORE COVERAGE BECOMES EFFECTIVE. I HEREBY AUTHORIZE TPAX OR MEDIPOINT MEDICAL MANAGEMENT TO OBTAIN FROM, RELEASE TO AND/OR DISCUSS INFORMATION RELATED TO MY MEDICAL AND MENTAL HEALTH DIAGNOSES AND TREATMENT. SUCH RECORDS AND INFORMATION MAY BE USED BY TPAX AND/OR MEDIPOINT MEDICAL MANAGEMENT NOW OR IN THE FUTURE TO ASSIST WITH MEDICAL CASE MANAGEMENT SERVICES AND THE CONSIDERATION OF ANY CLAIMS OR COVERAGE ISSUES.

EMPLOYEES SIGNATURE:_____ (REQUIRED) DATE:_____ (REQUIRED)

EMPLOYER AUTHORIZATION

DATE OF HIRE:_____ EFFECTIVE DATE:_____ LOCATION:_____

EMPLOYER APPROVED:_____ (REQUIRED) DATE:_____ (REQUIRED)