2027

Enrollment Guide

January 1st - December 31st

LEON HEALTH

H4286_PENROLLMENTKIT2027_M

WELCOME. 2

ENROLLMENT

Pre-Enrollment Checklist 3

Scope of Sales Appointment 5

Enrollment Request Form 7

Appointment of Representative 16

Authorization for Use & Disclosure of Health Information 18

Your Application Information . . . . . **Back Cover**

Welcome to Leon Health, Inc.

About Leon Health

LEON Health, launched in 2022 by Benjamín León, Jr., a visionary and innovator in the health care field, is a Medicare Advantage plan that works exclusively with Leon Medical Centers in Miami Dade county to provide Medicare, Medicare and Medicaid or Medicare for eligible seniors with disabilities with comprehensive care and the benefits needed in order to improve their overall health and well-being.

Leon Health currently offers four different plans each designed to fit the unique needs of each member and, aligned with Leon Medical Center's services with numerous health care professionals in the vast network serving nearly 40,000 Medicare recipients, Leon is redefining the delivery of medical care in the healthcare industry with a coordinated and integrated healthcare delivery system.

The Leon family has provided health and well-being to its beneficiaries in Miami-Dade County for over 50 years, and the Leon family continues to invest in innovation, physician trainings, center and service expansions and a health plan that has been customized to our Medicare community with the ultimate purpose of improving lives.

Need Help?

CALL

- Member Services at **1-844-969-5366** or **305-541-5366.**
- TTY users should call **711.**
- Our hours of operation are 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

VISIT

- www.leonhealth.com

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-844-969-5366** or **305-541-5366 (TTY users call 711).** Our hours of operation are from 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

UNDERSTANDING THE BENEFITS

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.LeonHealth.com or call 1-844-969-5366 to view a copy of the EOC.
- ☐ Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

UNDERSTANDING IMPORTANT RULES

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. Enrollees that have elected to enroll into Leon MediDual (HMO D-SNP) and Leon MediMax (HMO D-SNP) may not be subject to the Medicare Part B premium. For enrollees that have elected to enroll into Leon MediMore (HMO), Leon Health will cover up to $185 of your monthly Part B premium. You will receive the premium refund amount back on your monthly Social Security check. This process usually takes 90 days to go into effect.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.

- ☐ Except in emergency or urgent situations, we do not cover services provided by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).
- ☐ Leon MediDual and Leon MediMax are a dual eligible special needs plans (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Scope of Sales Appointment Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please initial below beside the type of product(s) you want the agent to discuss.

☐ **STAND ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)**

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

☐ **MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS**

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that must cover all Part A and Part B healthcare. In most HMOs, you can only go to doctors, specialists or hospitals in the plan's network, except in an emergency.

Medicare Health Maintenance Organization Point of Service (HMO-POS) Plan — A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Preferred Provider Organization (PPO) Plan — A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-For-Service (PFFS) Plan — A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment and terms and conditions.

Medicare Special Needs Plan (SNP) — A special type of Medicare Advantage Plan that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions.

Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — A type of health plan. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare covered services will be paid

for under the Original Medicare Plan (your Cost Plan pays for emergency services, or urgently needed services).

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Date of Appointment:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in):	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:

Enrollment Request Form Cover Page

OMB No. 0938-1378 (Expires:2/28/29)

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.

REMINDERS (continues)

- 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:

Leon Health, Inc.
P.O. Box 668230
Miami, FL 33166

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

HOW DO I GET HELP WITH THIS FORM?

Call Leon Health, Inc. at 1-844-969-5366. 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 Leon Health, Inc. al 1-844-969-5366 / TTY: 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ H4286-001 Leon MediExtra - $0 per month ☐ H4286-003 Leon MediMore - $0 per month

☐ H4286-002 Leon MediDual - $0 per month ☐ H4286-005 Leon MediMax - $0 per month

FIRST name:	LAST name:	Optional: Middle Initial:

Birth date: (MM/DD/YYYY) (_____/_____/_____)	Sex: ☐ Male ☐ Female	Phone number: ( )

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	[Optional: County]:	State:	ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Leon Health?

☐ Yes ☐ No

Name of other coverage: Member number for this coverage: Group number for this coverage

_____ _____ _____

Medicaid Eligibility Verification

H4286-002 MediDual: You must have QMB, SLMB, QI, or QDWI status. Are you currently enrolled in one of these categories?

☐ Yes ☐ No ☐ Not sure

H4286-005 MediMax: You must have FBDE, QMB+, or SLMB+ status. Are you currently enrolled in one of these categories?

☐ Yes ☐ No ☐ Not sure

Medicaid number, if available: _____

Leon Health will verify your Medicaid eligibility.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Leon Health, Inc.
- By joining this Medicare Advantage Plan, I acknowledge that Leon Health, Inc. will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Leon Health, Inc. coverage begins, I must get all of my medical and prescription drug benefits from Leon Health, Inc. Benefits and services provided by Leon Health, Inc. and contained in my Leon Health, Inc. "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Leon Health, Inc. will pay for benefits or services that are not covered.
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 by Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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 ☐ Data CD

Please contact Leon Health, Inc. at 1-844-969-5366 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year. TTY users can call 711.

Section 2 – All fields on this page are optional
Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No
List your Primary Care Physician (PCP), clinic, or health center:
Are you an existing member of this PCP? ☐ Yes ☐ No
Provider ID #
I want to get the following materials via email. Select one or more: ☐ Provider and Pharmacy Directory ☐ Explanation of Benefits (EOB) ☐ Comprehensive Formulary ☐ Summary of Benefits ☐ Evidence of Coverage (EOC) ☐ Dental Schedule of Benefits ☐ Over-the-Counter (OTC) Catalog Email address: _____

Paying your plan premiums
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or through our payment portal each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.** ☐ **Receive a monthly bill.** You may pay by mail or credit card. ☐ **Automatic deduction from my monthly Social Security benefit.** ☐ **Automatic deduction from my monthly Railroad Retirement Board benefit.** **If you have to pay a Part D Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** DON'T pay Leon Health, Inc. the Part D-IRMAA.

For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):
Received Date:	

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Leon Health, Inc. is an HMO plan with a Medicare contract. Enrollment in LEON Health, Inc. depends on contract renewal.

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 have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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) _____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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 an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ I pay a premium for Part A and I signed up for Part B during the General Enrollment Period (January 1 - March 31 each year). I want to join a Medicare drug plan (Part D) or Medicare Advantage Plan with drug coverage.
- ☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare Advantage Plan (with or without drug coverage).
- ☐ I signed up for Part A (Hospital Insurance) or Part B (Medical Insurance) during a Special Enrollment Period I qualified for because of an exceptional circumstance. I want to join a Medicare drug plan (Part D).

If none of these statements applies to you or you're not sure, please contact Leon Health, Inc. at 1-844-969-5366 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., seven days a week from October 1st through March 31st and Monday through Friday the rest of the year.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-969-5366 (TTY: 711) or speak to your provider.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0950
Expires: 12/31/2028

Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier
Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -
Signature	Date signed (mm/dd/yyyy) / /

Section 2: Information about the representative

This section must be completed by the representative.

Representative name

Professional status or relationship to the person in Section 1 (attorney, relative, etc.)

Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

Signature	Date signed (mm/dd/yyyy) / /

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) / /

Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.

Signature	Date signed (mm/dd/yyyy) / /

Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked "optional." If the person or entity appointing a representative doesn't have a Medicare number or National Provider Identifier, fill in "not applicable." Go to the regulation at 42 CFR 405.910: ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it's valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court), is required to have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative, and the court approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: HHS.gov/sites/default/files/OMHA-118.pdf

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE for more information.

Paperwork Reduction Act: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Instructions for completing the Member Authorization Form

01	Print your last name, first name and middle initials
02	Leon Health policy ID number
03	Write your date of birth in this format: mm/dd/yyyy
04	Write your full street address
05	Write your full, city, state, and ZIP code
06	Write your daytime phone number (including area code)
07	Write the full name of the person or entity that you want us to give your information to
08	Write the full street address of your authorized representative
09	Write the city, state, zip code of your authorized representative
10	This section tells us what information you would like us to release
11	Note the effective date of when this form will be valid. (MM/DD/YYYY)
12	Note the effective date of when this form will expire. (MM/DD/YYYY)
13	Sign your name and put the date on the form. Your name and signature must match the information in Member Information.
14	This section should only be filled out if you're signing as a personal representative, who has a legal representation, like a Power of Attorney. (Otherwise this section must be left blank.)

Member Information		
Name of Member:	**Member ID Number:**	**Birth Date:**
Street Address:		**City, State, Zip:**
Telephone Number:		

By completing and signing this form, you authorize Leon Health, Inc. to disclose protected health information to the below individuals, agencies or organizations:	
Individual(s)/agency/organization #1:	**Individual(s)/agency/organization #2:**
Street Address:	**Street Address:**
City, State, Zip Code:	**City, State, Zip Code:**
Telephone Number (including area code):	**Telephone Number (including area code):**

INFORMATION TO BE USED OR DISCLOSED

The following is a specific description of the health information I authorize to be used and/or disclosed:

I specifically request and authorize the disclosure of the following information: [Check all that apply]

☐ Mental Health	☐ Medical Records
☐ Enrollment and Disenrollment Information	☐ Prescription Drugs
☐ Claim Information	☐ Doctors and Hospital
☐ Referral/Authorization Information	☐ Developmental Disabilities
☐ Benefit records	☐ Alcohol and Other Drug Abuse
☐ Financial	☐ HIV Test Results
☐ Diagnosis	☐ Other (Specify):
☐ Treatment	_____

For the following Date(s):	
From:	To:

Your rights with respect to this Authorization

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Leon Health, Inc. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the plan's Member Services Department. I am aware that my withdrawal will not be effective until received by Leon Health, Inc. and will not be effective regarding the uses and/or disclosures of my health information that Leon Health, Inc. has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Member Services.

Redisclosure Notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Expiration Date: This authorization is good until the end date noted on the previous page, or if none noted, it is valid indefinitely unless I withdraw the authorization in writing.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Member/Legal Rep:	**Date:**

Important Note:

- **This space is only for the signature of the member or their legal representative.** If you are not the member's legal representative, **do not complete the following section.**
- If you are authorized to access the member's health information but are not their legal representative, **do not complete this section.**

Section for Legal Representatives Only:

- If you are the member's legal representative (e.g., you have Power of Attorney), complete the following information and attach the corresponding documentation.

  ☐ Check here if you are signing as a legal representative and fill out the blank spaces below. Please attach the corresponding documentation (e.g., Power of Attorney). This applies only if the person signing above is not the Leon Health member.

Personal Representative's Information:	
Name:	**Relationship to Member:**
Street Address:	**City, State, and Zip-Code:**
Telephone Number (including area code):	

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-969-5366 (TTY: 711) or speak to your provider.

Use this envelope to return your Enrollment Forms once completed.
No postage necessary.

Your Plan

PLAN NAME: _____

Effective Date: _____

Premium: _____

Deductible: _____

Electronic Enrollment Confirmation #: _____

LEON HEALTH