



A NEW ERA OF AGING

Online Enrollment Instructions

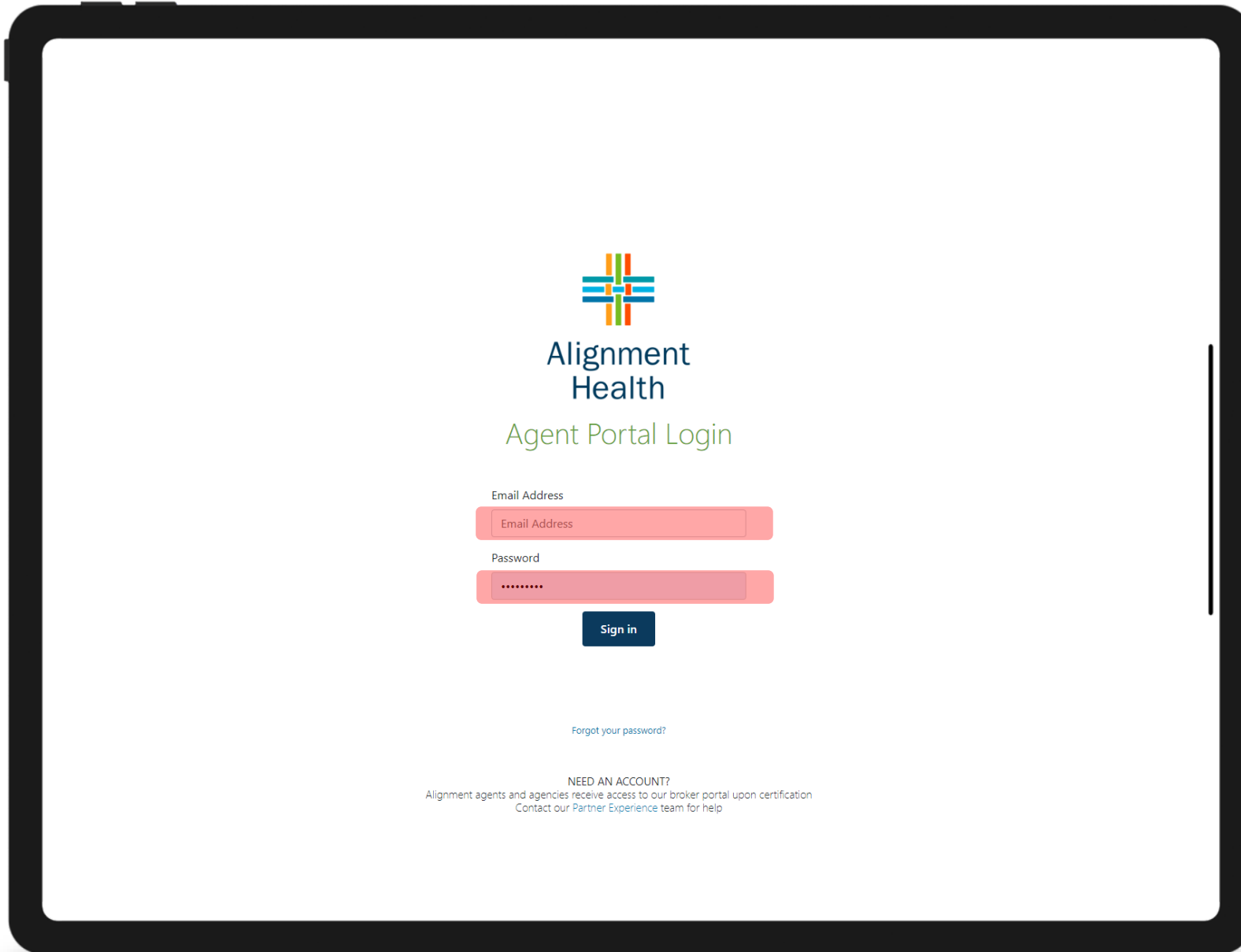


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ONLINE ENROLLMENT INSTRUCTIONS



STEP 1

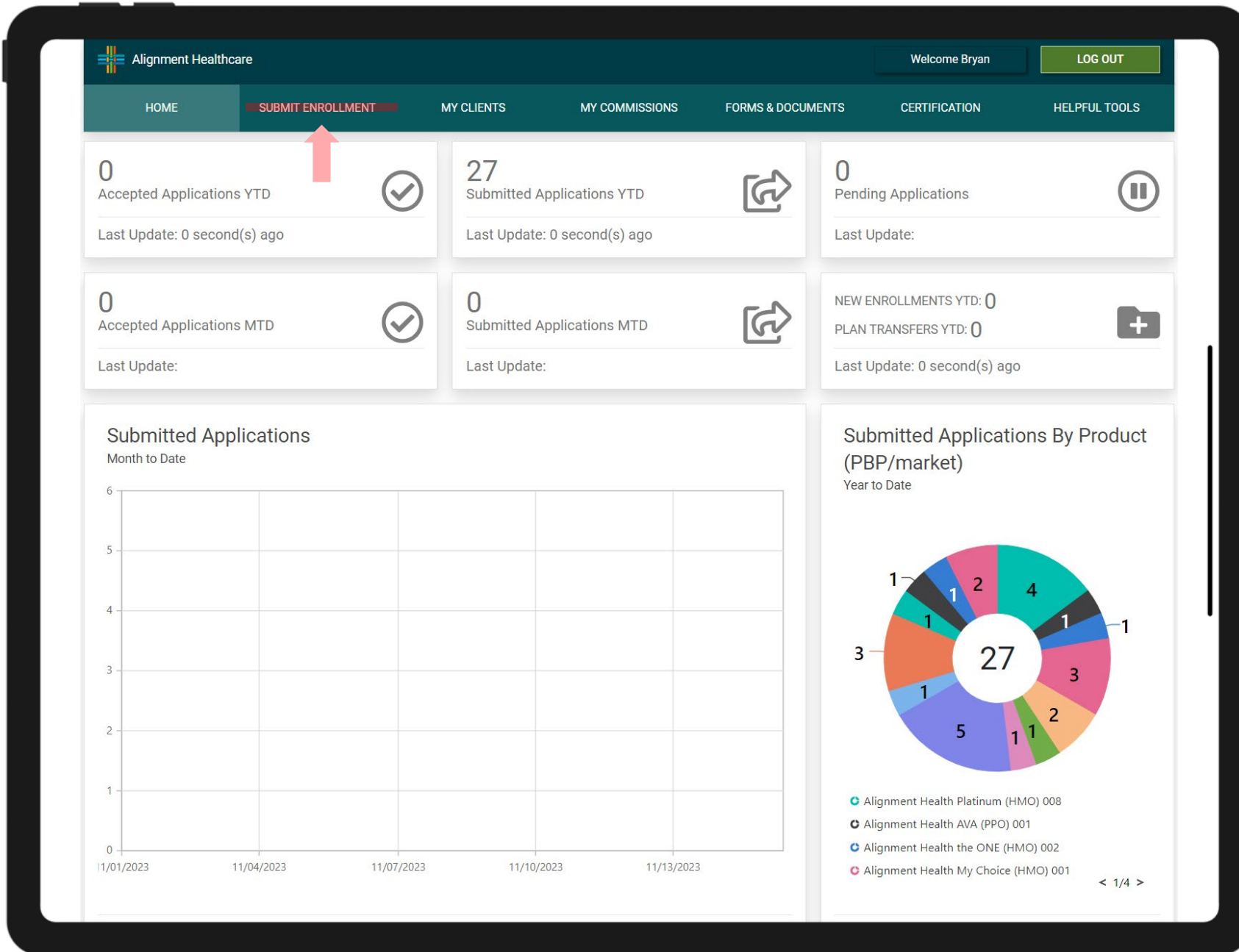
Go to:

<https://brokerportalalignmentprd.b2clogin.com/>

Enter Email Address and Password

Click on the “Sign in” button

ONLINE ENROLLMENT INSTRUCTIONS



STEP 2

Welcome to the Agent Portal Home Page

To submit an enrollment, click on Submit Enrollment header

ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healthcare

Welcome Bryan

LOG OUT

HOME SUBMIT ENROLLMENT MY CLIENTS MY COMMISSIONS FORMS & DOCUMENTS CERTIFICATION HELPFUL TOOLS

Enroll into an Alignment Healthcare plan

Review Scripts

Are you communicating with the client in person or telephonically? In Person By Phone

Do you want to record the conversation through Broker Portal? Yes No

i Before getting started, please enter your phone number as well as the client's and any other applicable parties.

Enter phone numbers to invite:

Agent Phone Number: *

801-123-4567

Client/Other Phone Numbers: *

801-123-4567

+ Add phone number

Start

STEP 3

Select the appropriate enrollment type

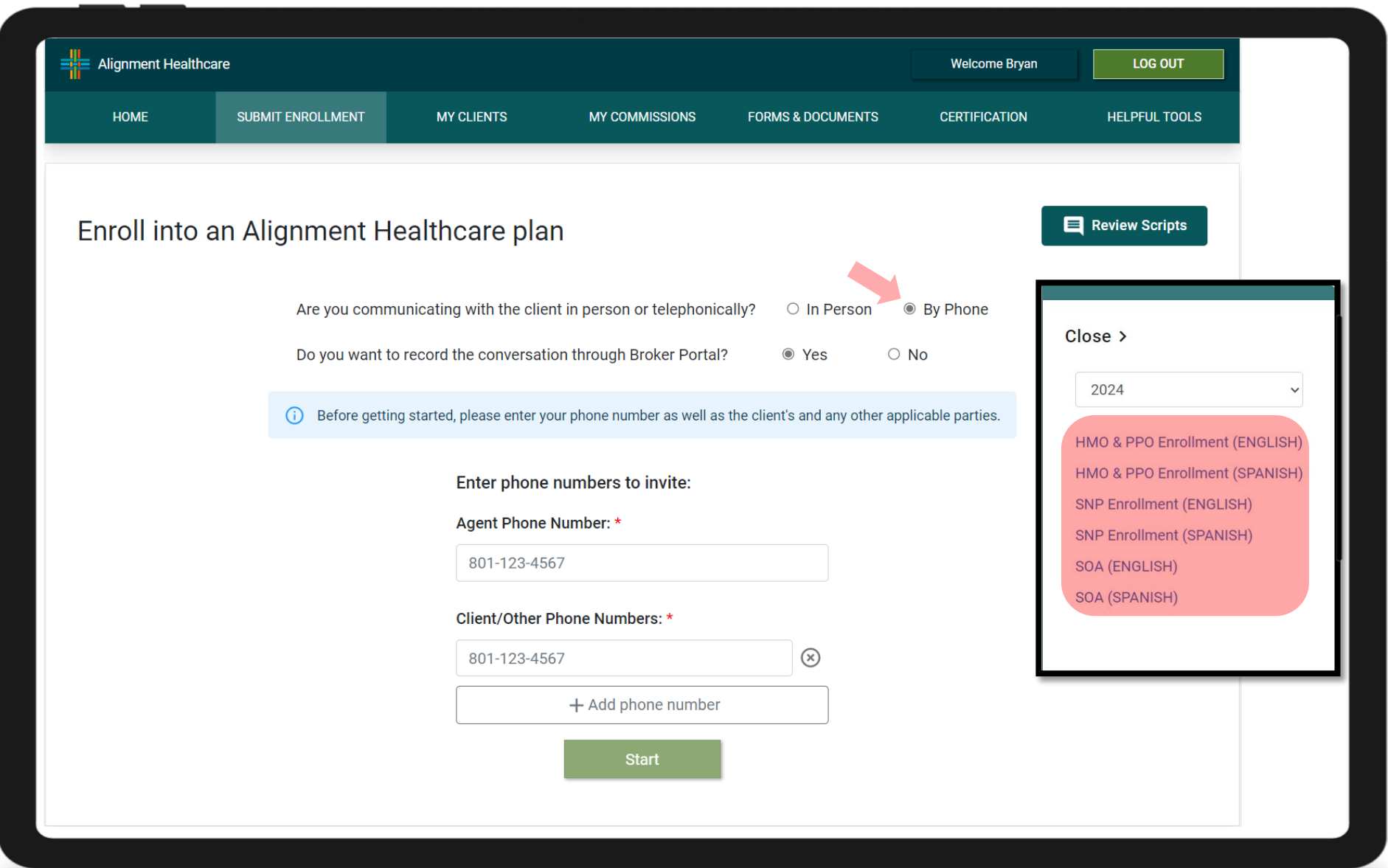
- In Person
 - Skip to step 4
- By Phone
 - Move to step 3A

ONLINE ENROLLMENT INSTRUCTIONS

STEP 3A

You will notice the phone scripts will populate on the right side of the screen.

Choose the appropriate script to use during your call



ONLINE ENROLLMENT INSTRUCTIONS

Alignment Healthcare

Welcome Bryan **LOG OUT**

HOME **SUBMIT ENROLLMENT** MY CLIENTS MY COMMISSIONS FORMS & DOCUMENTS CERTIFICATION HELPFUL TOOLS

Enroll into an Alignment Healthcare plan

Are you communicating with the client in person or telephonically? In Person By Phone

Do you want to record the conversation through Broker Portal? Yes No

Before getting started, please enter your phone number as well as the client's and any other applicable parties.

Enter phone numbers to invite:

Agent Phone Number: *

801-123-4567

Client/Other Phone Numbers: *

801-123-4567

+ Add phone number

Start

Review Scripts

Close >

2024

- HMO & PPO Enrollment (ENGLISH)
- HMO & PPO Enrollment (SPANISH)
- SNP Enrollment (ENGLISH)
- SNP Enrollment (SPANISH)
- SOA (ENGLISH)
- SOA (SPANISH)

STEP 3B

Make sure that you choose “Yes” to record the conversation through Broker Portal.

If you have your own or agency provided recording process you may choose “No”. There will be a checkbox that appears when you press “No” which will have you attest that you are responsible for recording the conversation and will maintain it for a duration of 10 years.

ONLINE ENROLLMENT INSTRUCTIONS

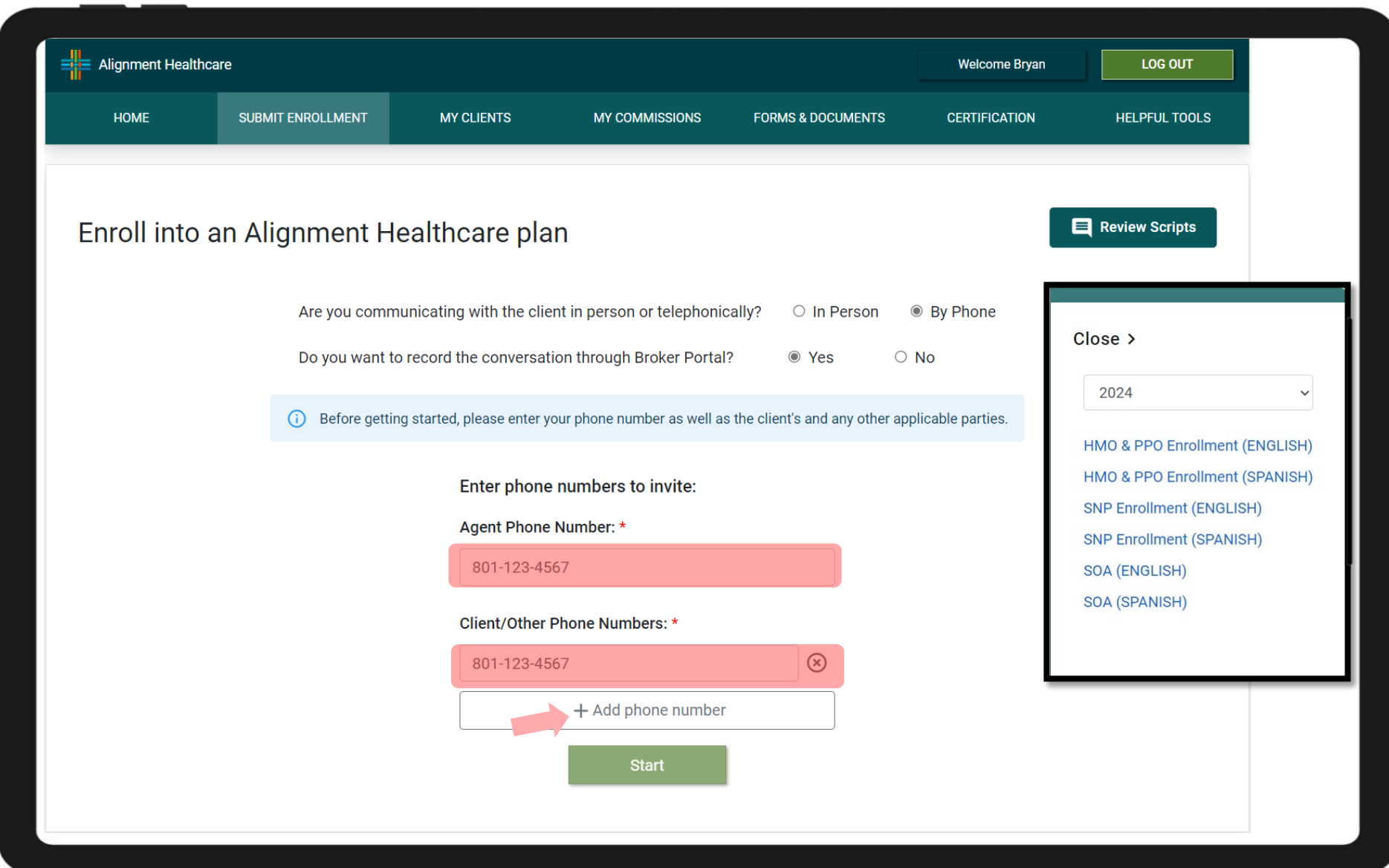
STEP 3D

Enter your phone number in the first space provided

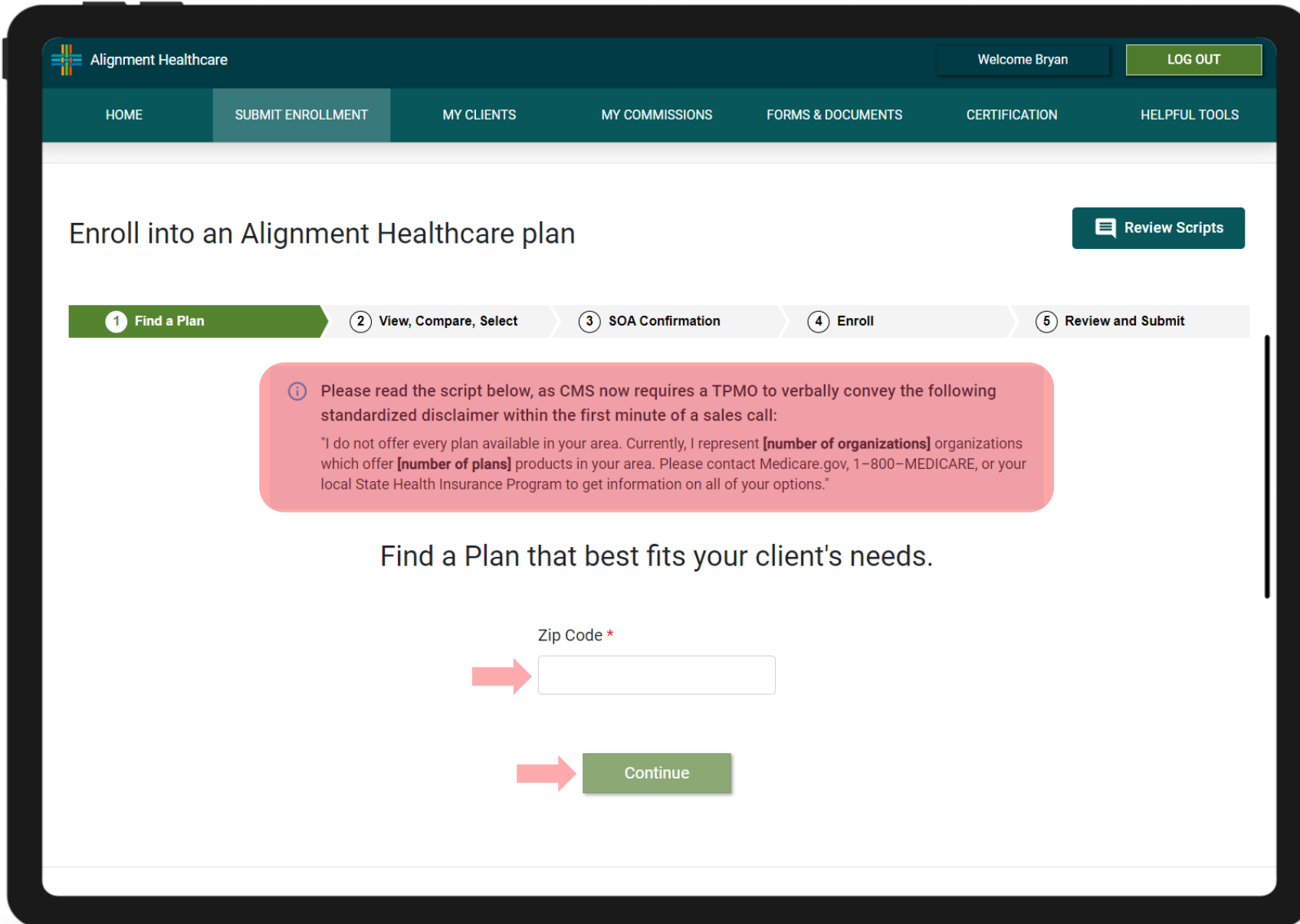
Then enter your client's number in the second space provided.

You may add another person to that call by pressing the "+Add phone number" button then entering their number.

When you add these numbers, the system will create a call room by calling the phone numbers and you will speak into your phone to record the call.



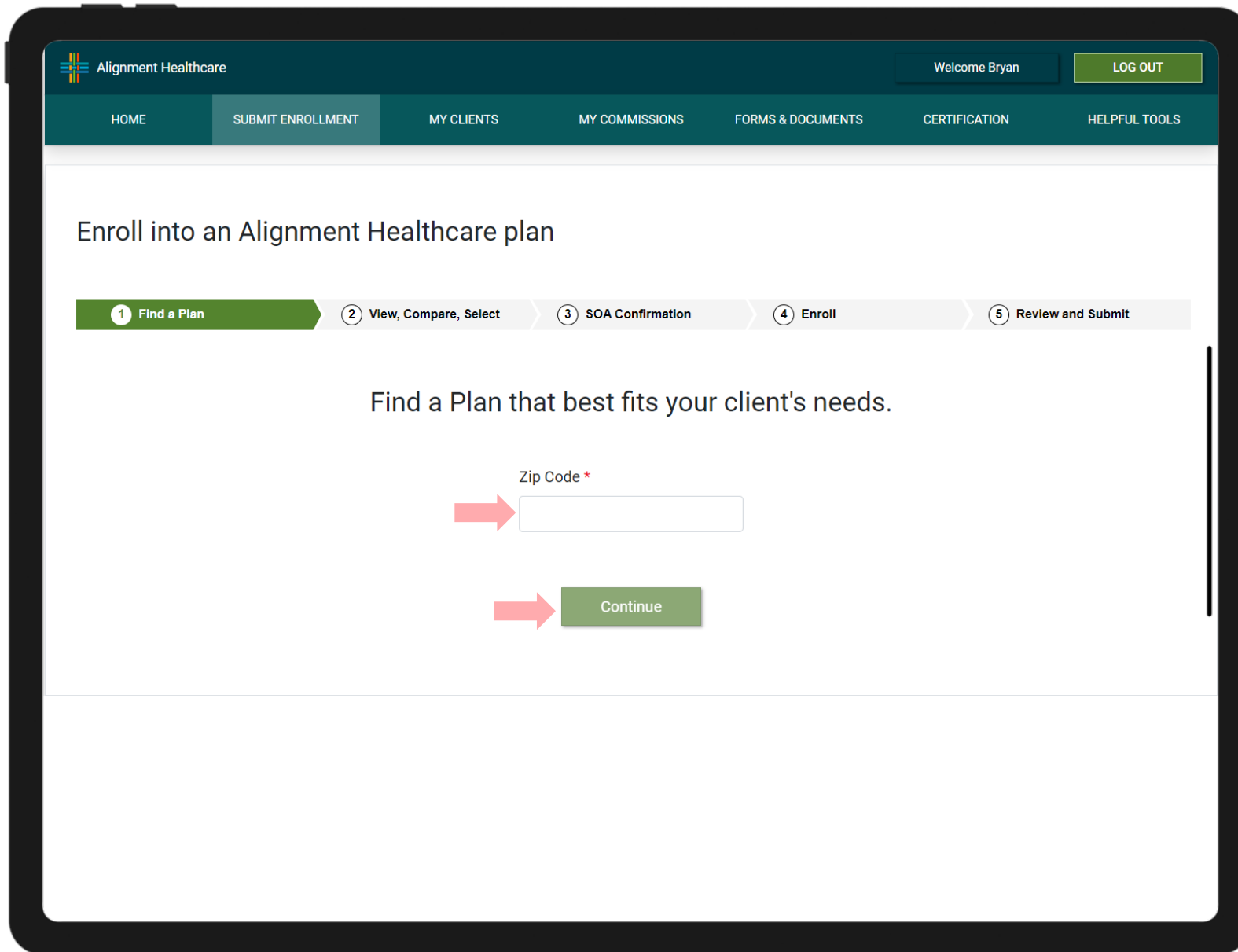
ONLINE ENROLLMENT INSTRUCTIONS



STEP 3E

- Read this disclaimer to your client
- Enter the beneficiary's Zip Code, and click Continue
- Skip to step 5

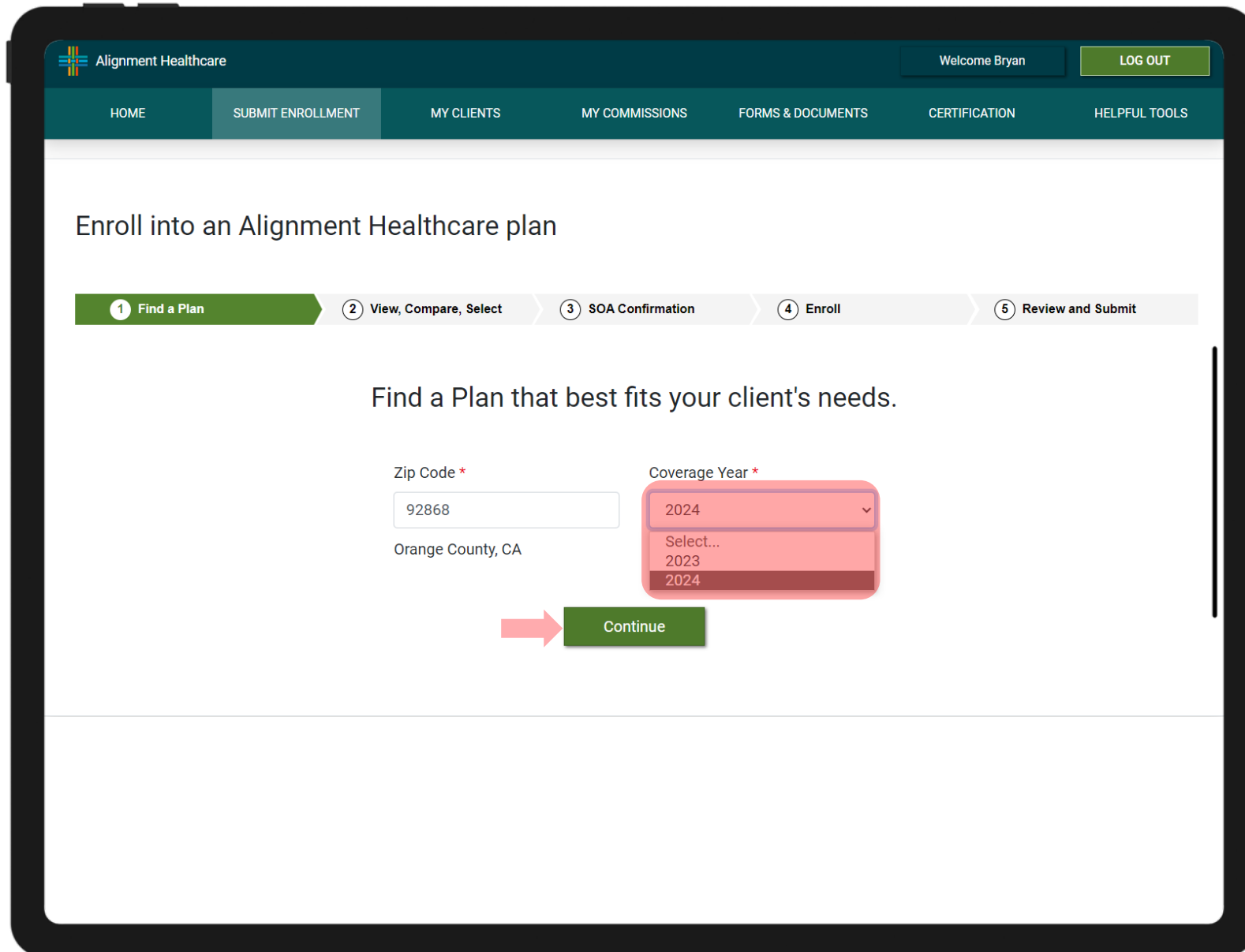
ONLINE ENROLLMENT INSTRUCTIONS



STEP 4

In Person: Enter the beneficiary's Zip Code, and click Continue

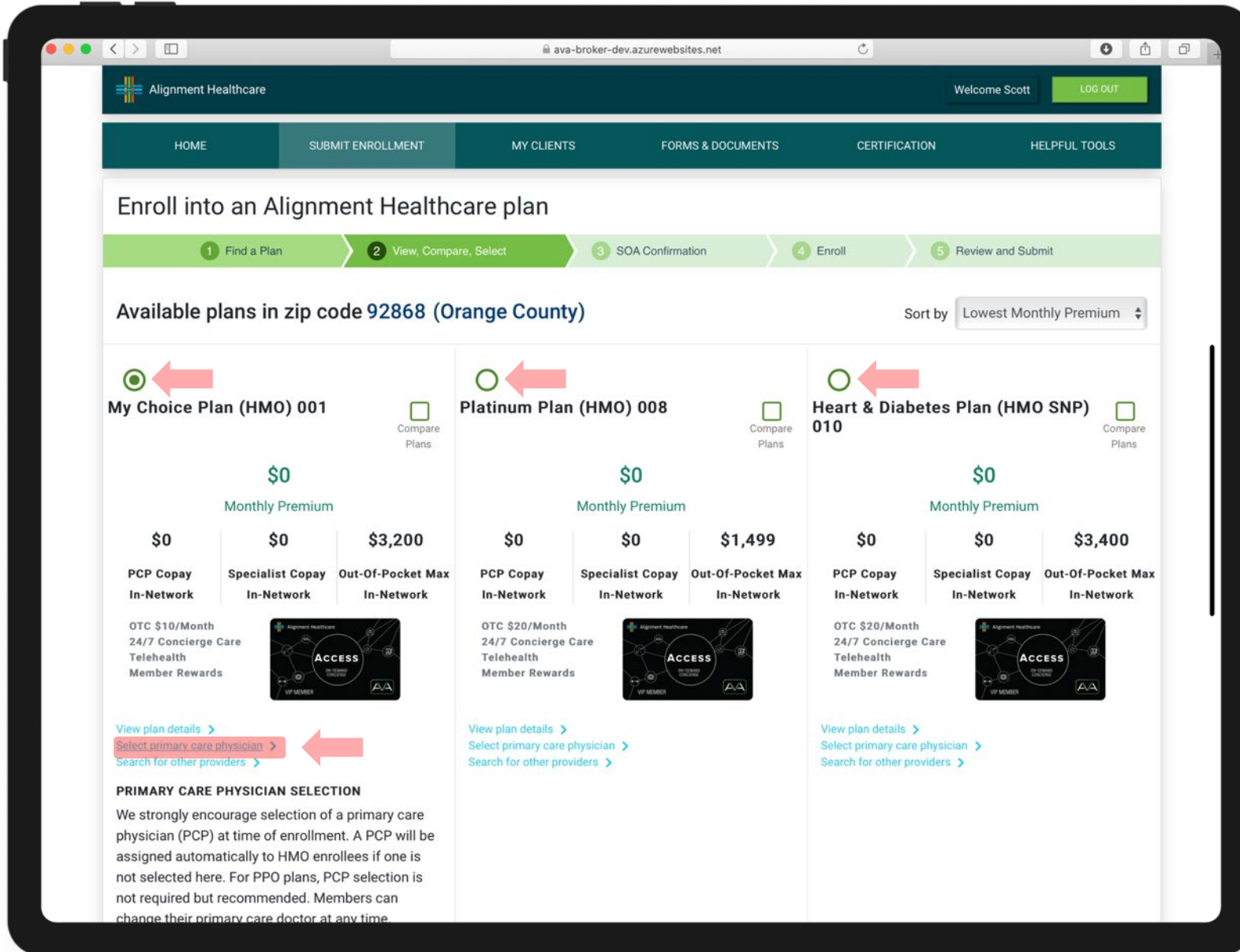
ONLINE ENROLLMENT INSTRUCTIONS



STEP 5

Select Coverage Year, and click Continue

ONLINE ENROLLMENT INSTRUCTIONS

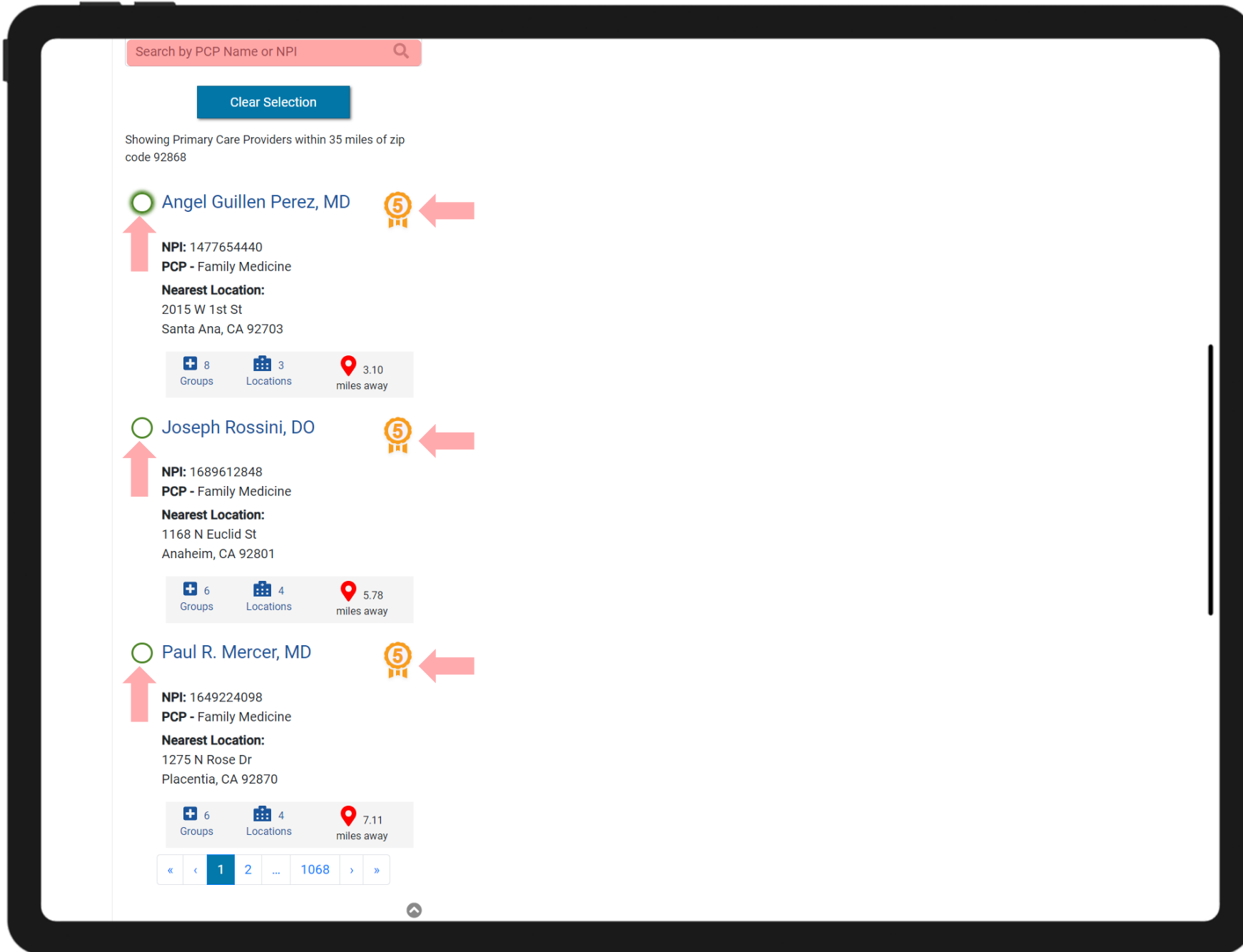


STEP 5

Select the Desired Plan

If enrolling into an HMO, you will need to Select Primary Care Physician

ONLINE ENROLLMENT INSTRUCTIONS

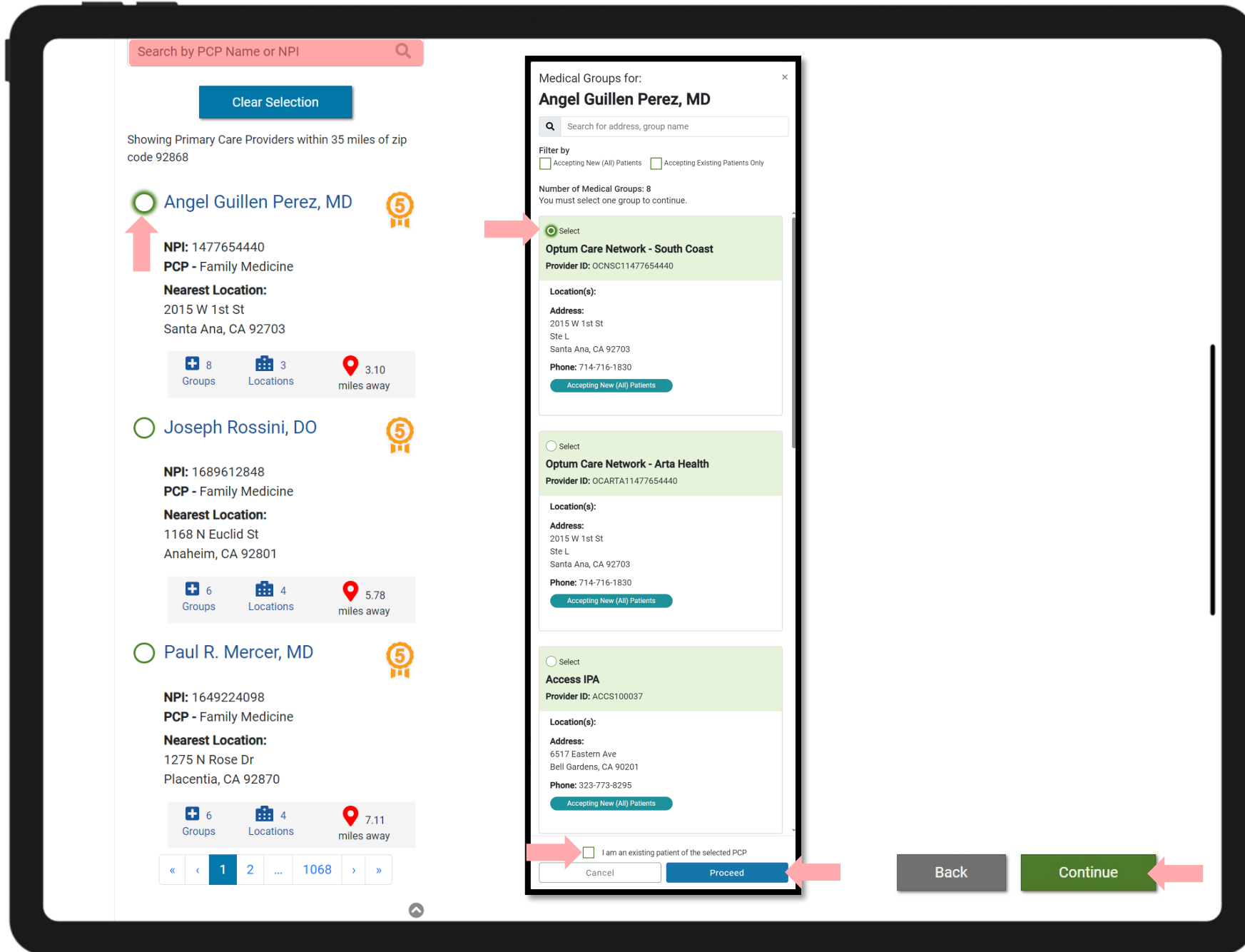


STEP 6

Select PCP by clicking on one of the preloaded names, or SEARCH by typing in the PCP's name

You will also notice there are ribbon ratings next to doctors' names. This is the High-Quality PCP badge it will only show on 4 or 5 star rated physicians

ONLINE ENROLLMENT INSTRUCTIONS



STEP 6 (cont)

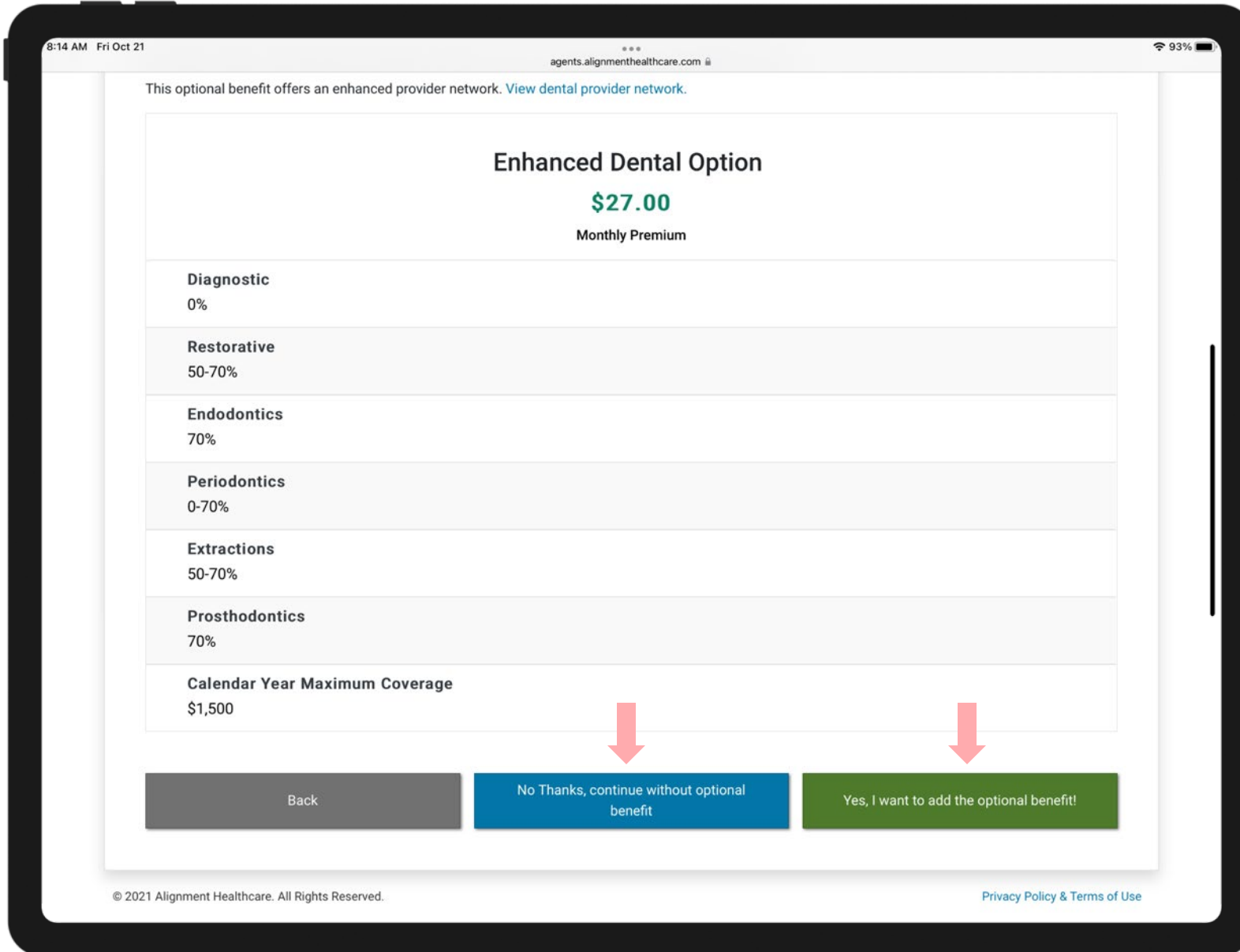
Once you click on desired PCP a pop-up box will open for you to select a MEDICAL GROUP

Check the box if they are an existing patient with that provider

Press the “Proceed” button

Scroll to the bottom of the page and press the green “Continue” button

ONLINE ENROLLMENT INSTRUCTIONS



STEP 6 (cont)

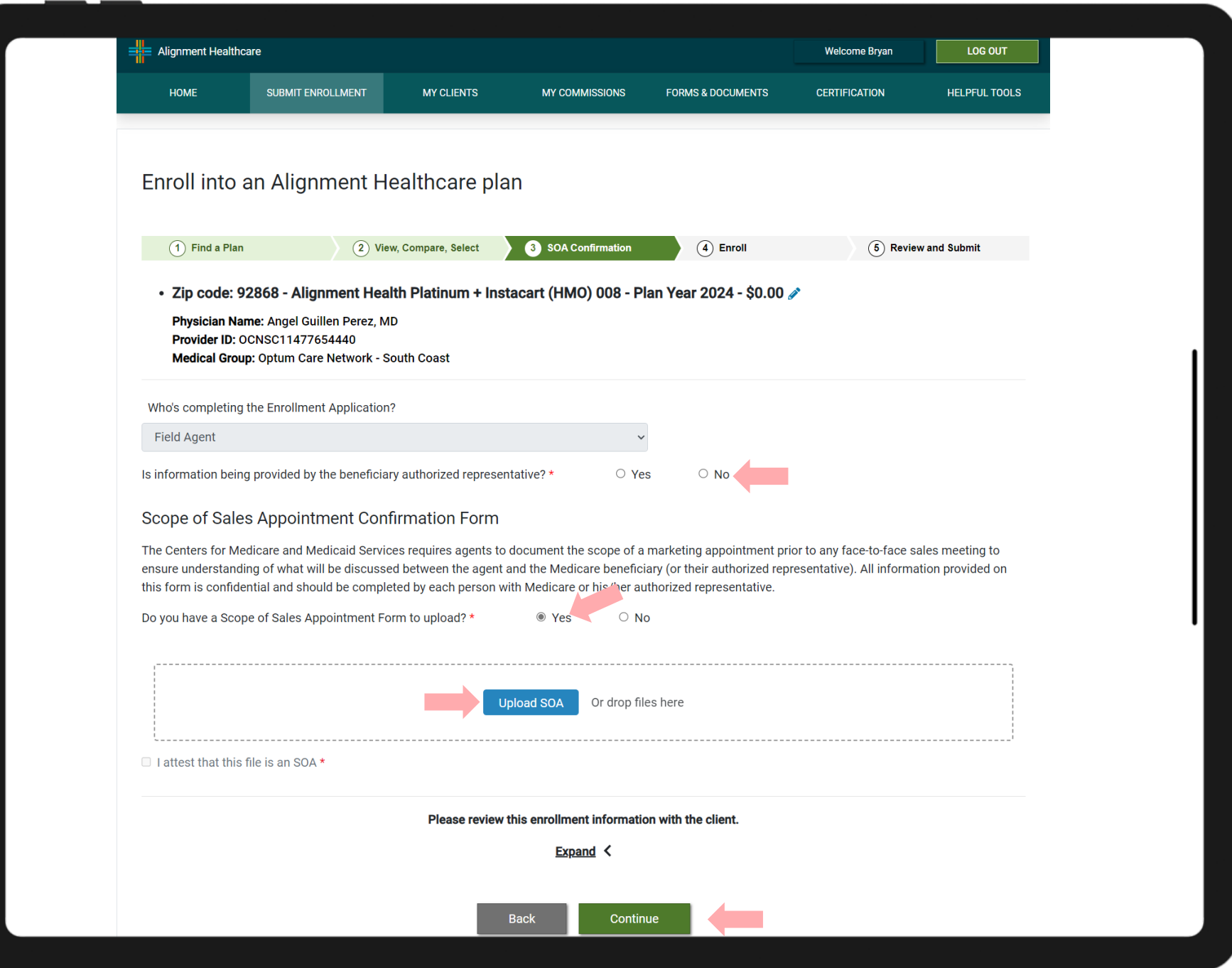
Optional Supplemental Buy-Up

Select whether member would like to enroll into the optional supplemental buy up

If yes, click on Yes, I want to add the optional benefit

If no, click on No Thanks, continue without optional benefit

ONLINE ENROLLMENT INSTRUCTIONS



STEP 7

If beneficiary has an authorized representative, you will upload a copy of the Power of Attorney (POA)

If you have a physical copy of the Scope of Appointment (SOA), you will upload a copy.

If you DO NOT have a physical copy of the Scope of Appointment (SOA), click NO

Scroll to the bottom of the page and press the green "Continue" button

ONLINE ENROLLMENT INSTRUCTIONS

Enroll into an Alignment Healthcare plan

- 1 Find a Plan
- 2 View, Compare, Select
- 3 SOA Confirmation
- 4 Enroll
- 5 Review and Submit

• Zip code: 92868 - Alignment Health Platinum + Instacart (HMO) 008 - Plan Year 2024 - \$0.00

Physician Name: Angel Guillen Perez, MD

Provider ID: OCNSC11477654440

Medical Group: Optum Care Network - South Coast

Who's completing the Enrollment Application?

Field Agent

Is information being provided by the beneficiary authorized representative? * Yes No

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face 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.

Do you have a Scope of Sales Appointment Form to upload? * Yes No

To be completed by applicant or authorized representative

Please initial below beside the type of product(s) you want the agent to discuss.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO)

A Medicare Advantage Plan that Provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

STEP 7 (CONT)

If you DO NOT have a physical copy of the Scope of Appointment (SOA), click NO

You will need to complete and electronic version of the Scope of Appointment (SOA)

ONLINE ENROLLMENT INSTRUCTIONS

By signing below, 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 below does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE

Signature - First and Last Name *

Date *

To be completed by Agent

Agent Name * Agent Phone *

Beneficiary Name Beneficiary Phone

Beneficiary Address

Initial Method of Contact *

Represented Plans *

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

AGENT SIGNATURE AND SIGNATURE DATE

Signature - First and Last Name *

Date Appointment Completed *

Scope of Appointment documentation is subject to CMS record retention requirements.
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

Provide brief explanation

Please review this enrollment information with the client.

[Expand](#) <

STEP 7 (CONT)

Once the Scope of Appointment (SOA), has been completed, scroll down and click CONTINUE

Please provide a brief description if the SOA is signed at the time of the appointment.

ONLINE ENROLLMENT INSTRUCTIONS

Enroll into an Alignment Healthcare plan

- 1 Find a Plan
- 2 View, Compare, Select
- 3 SOA Confirmation
- 4 Enroll
- 5 Review and Submit

1 - Medicare Advantage Eligibility Verification 2 - Client Information 3 - Additional Information

• Zip code: 92868 - Alignment Health Platinum + Instacart (HMO) 008 - Plan Year 2024 - \$0.00

Physician Name: Angel Guillen Perez, MD
Provider ID: OCNSC11477654440
Medical Group: Optum Care Network - South Coast

Medicare Advantage Eligibility Verification

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 recently was released from incarceration.
- I recently returned to the United States after living permanently outside of the U.S.
- I recently obtained lawful presence status in the United States.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).
- 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).
- 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 haven't had a change.

STEP 8

Select applicable Enrollment Reason

If enrolling during AEP, there is no need to select anything.

Scroll down and click CONTINUE

ONLINE ENROLLMENT INSTRUCTIONS

Enroll into an Alignment Healthcare plan

1 Find a Plan 2 View, Compare, Select 3 SOA Confirmation 4 Enroll 5 Review and Submit

1 - Medicare Advantage Eligibility Verification 2 - Client Information 3 - Additional Information

- Zip code: 92868 - Alignment Health Platinum + Instacart (HMO) 008 - Plan Year 2024 - \$0.00

Physician Name: Angel Guillen Perez, MD
Provider ID: OCNSC11477654440
Medical Group: Optum Care Network - South Coast

Applicant Information


Lead ID # (Alignment Internal Use Only)

Proposed Effective Date

Medicare Information

Please take out your red, white, and blue Medicare card to complete this section. In the spaces provided, enter your Medicare Number (do not enter dashes) and the Effective Dates for your Part A and Part B coverage.

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



Medicare ID # * Last Name * Date Of Birth *

STEP 9

Ensure you have the correct PROPOSED EFFECTIVE DATE

Enter the beneficiary's Medicare number, last name and DOB and click VERIFY to automatically fill in the effective dates

If the system does not automatically fill in the Part A/B effective dates, please complete manually

ONLINE ENROLLMENT INSTRUCTIONS

Client Details

First Name * Middle Initial Last Name * Date Of Birth *

Gender *

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

What's your race? Select all that apply.

Select one if you want us to send you information in a language other than English

Permanent Address

Address Line 1 * Address Line 2 City * State *

Do not enter a P.O. Box

Zip Code *

Is mailing address the same as permanent address? * Yes No

Contact Information

Home Phone # * Cell Phone # Email *

Emergency Contact Information

First Name Middle Initial Last Name Relationship to Client

STEP 9 (cont)

Fill in all Required Fields

Scroll down and click CONTINUE

EMAIL REQUIREMENT WILL BE REVIEWED ON NEXT PAGE

ONLINE ENROLLMENT INSTRUCTIONS

6:26 AM Fri Oct 21 agents.alignmenthealthcare.com 90%

92618

Is mailing address the same as permanent address? * Yes No

Contact Information

Home Phone # * Cell Phone # Email *

Emergency Contact Information

First Name Middle Initial Last Name Relationship to Client

Primary Phone # Email

Select one if you want us to send you information in an accessible format Braille Large Print

Please contact Alignment Health Plan at 1-866-634-2247 (TTY 711) 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., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Do you work? Yes No

Does your spouse work? Yes No

The following materials will be sent to you via email unless you prefer to receive a printed copy. Please check below if you prefer to receive a printed version.

Part C Explanation of Benefits (EOB)
 Part D Explanation of Benefits (EOB).
 Annual Notice of Change (ANOC)

Back Continue

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STEP 9 (cont)

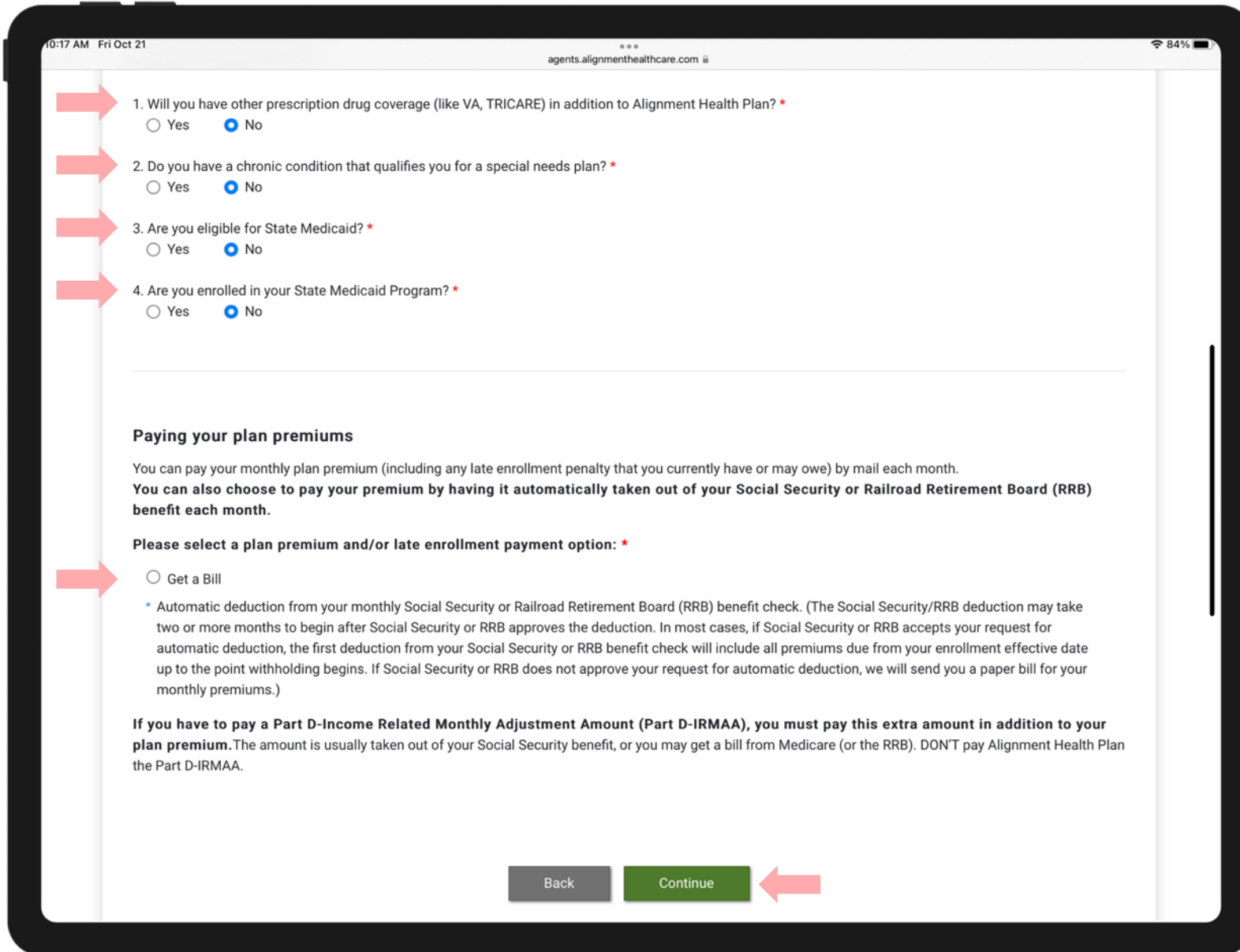
Email Requirement

System defaults to require email based on the last portion of this page.

If member has an email, please fill in member email.

If member DOES NOT have an email, make sure the 3 boxes are checked off for Part C/D EOB, ANOC

ONLINE ENROLLMENT INSTRUCTIONS



STEP 10 (cont)

Answer the required questions and select how the member would like to pay for their Monthly Plan Premium

Scroll down and click CONTINUE

ONLINE ENROLLMENT INSTRUCTIONS

Enroll into an Alignment Healthcare plan

- 1 Find a Plan
- 2 View, Compare, Select
- 3 SOA Confirmation
- 4 Enroll
- 5 Review and Submit

Zip code: 92868 - Alignment Health Platinum + Instacart (HMO) 008 - Effective Date:
01/01/2024 - Test Tester

Review Enrollment Application

Alignment Health Platinum + Instacart (HMO) 008 

Primary Care Provider

PCP: **Angel Guillen Perez, MD**
Phone Number: **7147161830**
Medical Group: **Optum Care Network - South Coast**
ID: **OCNSC11477654440**

Who is completing the Enrollment Application?

Full Name: BRYAN HO	Address: TEST ADDRESS UPDATED
Phone Number: 4433222222	City: TEST CITY
	State: CA

Medicare Information

Your Medicare Beneficiary Number: 1EG4TE5MK74	Hospital Insurance Benefits (Part A) Date: Medical Insurance Benefits (Part B) Date:
---	---




STEP 11

Review all information and Scroll Down

ONLINE ENROLLMENT INSTRUCTIONS

Applicant Information

Last Name: **Tester**
First Name: **Test**
Residence Address: **123 Fake Street**
City: **Orange**
State: **CA**
Zip Code: **92868**

Mailing Address: **123 Fake Street**
Phone Number: 
Gender: **Male**
Date of Birth: **02/15/1950**
Email:


Emergency Contact


Last Name:
First Name:
Phone Number:

Email:
Relationship to Enrollee:

Payment Option

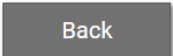
Get a Bill

Do you want to upload a paper application? * Yes No 

 Or drop files here

Agent Signature Date on Paper Application *

mm/dd/yyyy 

STEP 11 (cont)

If you have a physical copy of the Enrollment Application, you will upload a copy.

If you DO NOT have a physical copy of the Enrollment Application, click NO

ONLINE ENROLLMENT INSTRUCTIONS

Do you want to upload a paper application? * Yes No

IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Alignment Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Alignment Health Plan 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.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Alignment Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Alignment Health Plan. Benefits and services provided by Alignment Health Plan and contained in my Alignment Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alignment Health Plan will pay for benefits or services that are not covered.
- 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.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 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.

Electronic Signature Agreement

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Signature of Beneficiary or Authorized Representative *

Signature Date *

AGENT SIGNATURE AGREEMENT

By signing below, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

Agent Signature *

Signature Date *

Back

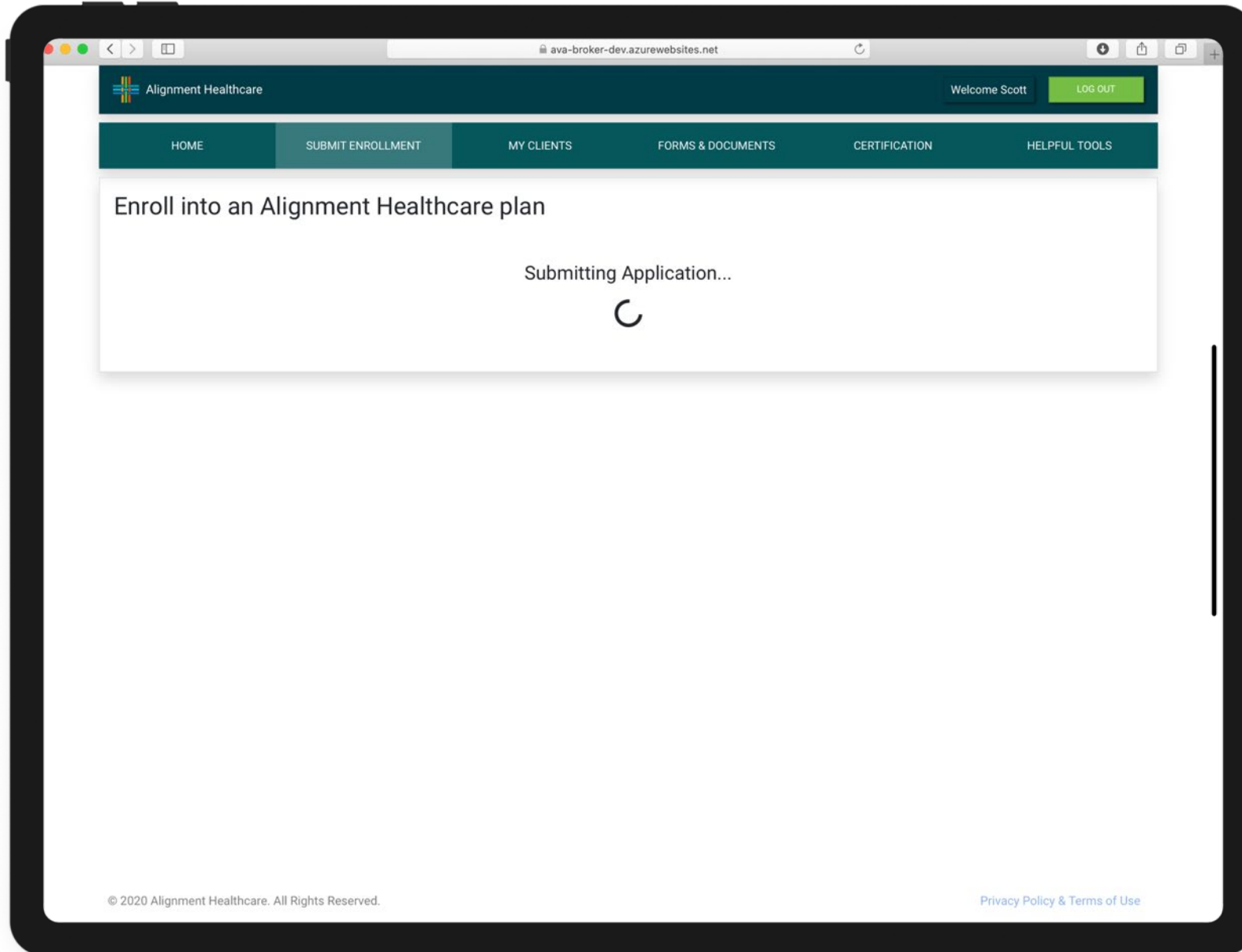
Submit Application

STEP 11 (CONT)

If you DO NOT have a physical copy of the Enrollment Application, click NO

Complete the information, scroll down and click Submit Application

ONLINE ENROLLMENT INSTRUCTIONS



STEP 12

You've now submitted the Enrollment Application

ONLINE ENROLLMENT INSTRUCTIONS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Authorization: I authorize Alignment Health Plan to release my personal health information to the pharmacy or other medical supplies to me to disclose information to me.

Effective Period: This authorization is valid for the periods of health care.

Extent of Authorization

- I authorize the release of my personal health information to the healthcare, community health center, or other healthcare provider.
- Only the following:

Use: Alignment Health Plan will use your personal health information as allowed by CMS.

Benefits: I understand that my benefits are conditioned on whether I provide this information.

Rights and Responsibilities: I understand my personal health information rights and responsibilities required by these laws. I understand the Evidence of Coverage Card and I can do that at any time.

SIGNATURE

Signature of Member or Personal Representative

Name of Member or Personal Representative

If signed by someone other than the member, please print name and relationship to member.



CONTINUITY OF CARE FORM



Member Information			
Name:	DOB:	Language:	
Address:		Phone #: _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home	
Who Cares for You Most Often?	Name/Phone#:		
Have you ever served, or currently serve, in the US military	<input type="checkbox"/> Previously Served	<input type="checkbox"/> Currently Serving	<input type="checkbox"/> No
	<input type="checkbox"/> Not Able to Obtain	<input type="checkbox"/> Refused to Answer	
Provider Information			
Medical Group:	PCP Name/Phone #:		
1. Do you currently rent any of the following durable medical equipment or medical supplies? <input type="checkbox"/> N/A			
Wheelchair	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Hospital Bed	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Oxygen	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Power Operated Vehicle	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Nebulizer	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
CPAP	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Ostomy Supplies	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Glucometer (brand of glucometer)	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
Other:	Name of Supplier:	Phone #:	<input type="checkbox"/> Own
2. Do you currently see any specialists <input type="checkbox"/> N/A			
Specialty 1:	Provider:	Phone #:	Appts?
Specialty 2:	Provider:	Phone #:	Appts?
Specialty 3:	Provider:	Phone #:	Appts?
Are you receiving any chemotherapy or radiation services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provider Name and Phone #:		
Are you receiving any home health Services by a nurse or physical therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provider Name and Phone #:		
Any other procedure or surgeries that are scheduled for ON or AFTER your enrollment date:	Procedure: _____	Date: _____	
	Provider: _____	Phone #: _____	

STEP 13

Continuity of Care Form

Continuity of Care (COC) form is not available through the online enrollment process and must be submitted to Alignment Health Plan either by:

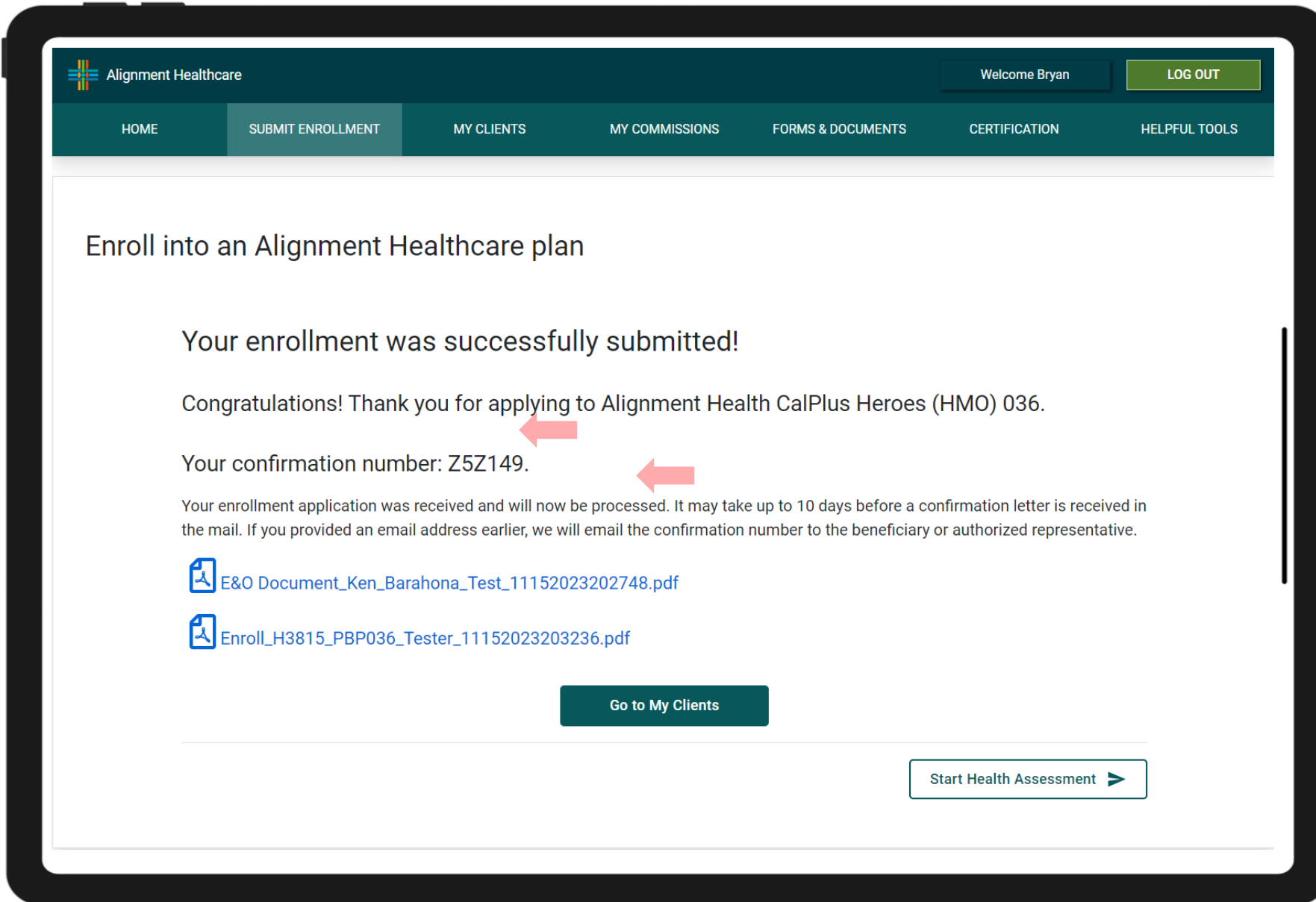
FAX: 562.207.4623

EMAIL: [Encrypted] to COC@ahcusa.com

The COC form is available on your Broker portal under:

FORMS & DOCUMENTS

ONLINE ENROLLMENT INSTRUCTIONS



STEP 12 (cont)

You've now submitted the Enrollment Application

You'll be able to:

- View a copy of the Enrollment Application
- View a copy of the Scope of Appointment
- Start the HRA

AS ALWAYS, IF YOU

HAVE ANY QUESTIONS

CALL US / EMAIL TODAY

888-793-5700 /

PartnerExperience@ahcusa.com



Alignment Health Plan®