DEDUCTIBLE CARRY OVER CREDIT REPORT

(For Current Calendar Year Only)

☐ **PRODUCT:**

Ambetter EPO

Please complete the required form, provide prior carriers statement, and mail to:
Ambetter from WellCare of New Jersey
Attention: Accumulator Department
480 Crosspoint Parkway
Getzville, NY 14068

SUBSCRIBER INFORMATION (FORMER INSURER INFORMATION) ☐ ***Family Plan*** ☐ ***Employer Plan***

SUBSCRIBER'S LAST NAME		FIRST NAME			MIDDLE NAME
ADDRESS STREET	CITY	STATE	ZIP		PHONE #
SUBSCRIBER'S ID NUMBER	SS#	DATE OF BIRTH	MONTH	DAY	YEAR
INSURER CARRIER NAME	GROUP NAME (EMPLOYER)	POLICY NUMBER	GROUP NUMBER		INSURER PHONE #

SUBSCRIBER'S ISSUED AMBETTER ID NUMBER ______________________________

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

What is the effective date ____________________ ***and end date*** ______________________ ***of your previous policy?***

List any former names you or a dependent were listed under on your previous policy, if applicable:

____.

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ______________________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ______________________________

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ______________________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ______________________________

AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ______________________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

DEPENDENT(S) INFORMATION (Continued)

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ____________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ____________________
AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ____________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ____________________
AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ____________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ____________________
AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

DEPENDENT(S) INFORMATION

LAST NAME	FIRST NAME	SS#	DATE OF BIRTH	MONTH	DAY	YEAR

CHECK DEPENDENT'S RELATIONSHIP TO SUBSCRIBER (if other, list relationship)

☐ HUSBAND ☐ SON ☐ OTHER, ____________________
☐ WIFE ☐ DAUGHTER

MEMBER'S ISSUED AMBETTER ID NUMBER ____________________
AMOUNT APPLIED TO DEDUCTIBLE WITH PRIOR CARRIER ____________________

INCLUDE A COPY OF PRIOR CARRIER'S STATEMENT OF PAYMENT FORM (See instructions for details)

For Ambetter from WellCare of New Jersey Members: Deductible carry over applies only to those services which are covered benefits under the medical portion of your contract.

IMPORTANT: **READ INSTRUCTIONS AND CARRY FORWARD REQUIREMENTS PRIOR TO COMPLETING ATTACHED FORM**

NOTE TO SUBSCRIBER

Deductible Credit: For the first Calendar Year of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same Calendar Year that your first Calendar Year starts under this Policy provided there has been **no lapse in coverage** between the previous coverage and this Policy.

This credit will be applied whether your previous coverage was under a plan with us or with another carrier. You will be required to provide us with adequate documentation of the amounts satisfied.

Note: There is no Coinsurance credit from previous coverage [unless the Covered Person is entitled to a cost sharing reduction under Federal law and as a result of an eligibility change replaces a prior policy issued by Us with this Policy where both policies have the same classification of coverage and provided there has been no lapse in coverage between the previous policy and this Policy.] In addition, there is no Deductible or Coinsurance carryover into the next Calendar Year.

INSTRUCTIONS TO SUBSCRIBER

In order to promptly facilitate your request please ensure that all fields of this form are completed and all supporting documentation are supplied at the time of form submission.

1. You must provide proof of cost share information from previous insurance carrier, including any Deductibles and Maximum Out of Pocket incurred during the effective and end date of your former policy. Please note that cost share information from former carrier must be supplied in the form of an EOB or official letter on former carrier letterhead.
2. Please check box to indicate if this is an Individual Family Plan or Employer Plan.
3. Provide full name; First Last and Middle full address, city, state, zip code and phone number.
4. If you were on a family plan policy please enter your policy number under the subscriber's ID number. **Note**: if your policy was held under an employer plan please fill out Group (Employer) details.
5. Please include your Ambetter Issued ID number.
6. Please indicate the total in deductible that is shown on the proof of cost share information.
7. Provide the effective and end date of your policy.
8. List any former names used on any policies

INSTRUCTIONS FOR DEPENDANTS

In order to promptly facilitate your request please ensure that all fields of this form are completed and all supporting documentation are supplied at the time of form submission.

1. You must provide proof of cost share information from previous insurance carrier, including any Deductibles and Maximum Out of Pocket incurred during the effective and end date of your former policy. Please note that cost share information from former carrier must be supplied in the form of an EOB or official letter on former carrier letterhead.
2. Provide full name; First Last and Middle, Date of Birth
3. Please provide relationship of dependent to subscriber.
4. Please include Ambetter Issued ID number for dependent.
5. Please indicate the total in deductible that is shown on the proof of cost share information.
6. Once completed mail the request form and proof of cost share information to:

Ambetter from WellCare of New Jersey
Attention: Accumulator Department
480 Crosspoint Parkway
Getzville, NY 14068

Statement of Non-Discrimination

Ambetter from WellCare of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from WellCare of New Jersey does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from WellCare of New Jersey:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from WellCare of New Jersey at 1-844-606-1926 (TTY 711).

If you believe that Ambetter from WellCare of New Jersey has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter from WellCare of New Jersey, Attn: Appeals and Grievances, PO Box 10341 Van Nuys, CA, 91410, 1-844-606-1926 (TTY 711), Fax 1-833-886-7956.
You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from WellCare of New Jersey is available to help you. You can also file a civil rights complaint with the U.S.

Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter from WellCare of New Jersey, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-606-1926 (TTY 711).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from WellCare of New Jersey 方面的問題， 您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-844-606-1926 (TTY 711)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from WellCare of New Jersey 에 관해서 질문이 있다면 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-606-1926 (TTY 711) 번으로 전화하십시오.
Portuguese:	Se você ou alguém que estiver a ajudar tiver dúvidas sobre a Ambetter from WellCare of New Jersey, tem o direito de obter ajuda e informações no seu idioma gratuitamente. Para falar com um intérprete, ligue para 1-844-606-1926 (TTY 711).
Gujarati:	જો તમને, અથવા તમે કોઇની મદદ કરી રહ્યાં હોવ તેમને, Ambetter from WellCare of New Jersey વિશે કોઈ પ્રશ્નો હોય તો, તમને કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1-844-606-1926 (TTY 711) ઉપર કૉલ કરો.
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat planów oferowanych za pośrednictwem Ambetter from WellCare of New Jersey, to macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-844-606-1926 (TTY 711).
Italian:	Nel caso in cui Lei, o una persona che Lei sta aiutando, dovesse avere domande su Ambetter from WellCare of New Jersey, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiamare il l'1-844-606-1926 (TTY 711).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حولAmbetter from WellCare of New Jersey ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-606-1926 (TTY 711).
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from WellCare of New Jersey, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-606-1926 (TTY 711).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from WellCare of New Jersey вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-844-606-1926 (TTY 711).
French Creole:	Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Ambetter from WellCare of New Jersey, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-844-606-1926 (TTY 711).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from WellCare of New Jersey के बारे में कोई सवाल हों, तो आपको बिना किसी ख़र्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-844-606-1926 (TTY 711) पर कॉल करें।
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from WellCare of New Jersey, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-606-1926 (TTY 711).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from WellCare of New Jersey, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez-le 1-844-606-1926 (TTY 711).
Urdu:	اگر Ambetter from WellCare of New Jersey کے بارے میں آپ کے، یا جن کی آپ مدد کر رہے ہیں، ان کے سوالات ہوں تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے (TTY 711) 1-844-606-1926 پر کال کریں۔