



# **New Member Medicare Information in myETF Benefits**

# ***New Medicare Info in MEBs...***

- ❖ **Medicare Parts A & B [see slide 3]**
  - ✓ Termination Date
  
- ❖ **Medicare Parts C & D [see slide 3]**
  - ✓ Effective Date
  - ✓ Termination Date
  - ✓ Contractor Number
  
- ❖ **ESRD (End Stage Renal Disease) [see slide 3]**
  - ✓ Coordination Period Start Date
  - ✓ Coordination Period End Date
  
- ❖ **Medicare Blank Reason [see slides 3 & 4]**



# ***New Medicare Info in MEBs...***

## **Other Health Insurance:**

PLAN	Insurance Company: DEAN HEALTH	Group Number: 18257	Policy Number: 123456789
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## **Medicare:**

Medicare Eligibility Reason:	Medicare A Effective Date:	Medicare B Effective Date:
Health Insurance Claim Number:	Medicare A Expiration Date:	Medicare B Expiration Date:
Medicare Blank Reason:		

## **Additional Medicare Info:**

Medicare C Effective Date:	Medicare D Effective Date:	ESRD Start Date:
Medicare C Expiration Date:	Medicare D Expiration Date:	ESRD End Date:
Medicare C Contract No:	Medicare D Contract No:	

# ***New Medicare Info in MEBs...***

Other Health Insurance: <input type="text" value="NO"/>	
<input type="text"/>	
Medicare: <input type="text" value="YES"/>	
Medicare Eligibility Reason: <input type="text" value="AGE"/>	Medicare A Effective Date: <input type="text"/> 
Health Insurance Claim Number: <input type="text" value="123456789A"/>	Medicare B Effective Date: <input type="text" value="01/01/2014"/> 
Medicare Info Blank Reasons: <input type="text" value="Select One"/>	
<input type="text" value="Incomplete Information"/>	
<input type="text" value="Survivor with Family1 Contract"/>	
<input type="text" value="Other Non-State Primary Coverage"/>	
<input type="text" value="Part B Declined"/>	
<input type="text" value="Grandfathered Contract"/>	
<input type="text" value="Federal Employee"/>	
<input type="text" value="Not Eligible For Part A"/>	
Physician:	
National Provider ID: <input type="text"/>	Last/Clinic Name: <input type="text" value="DEAN CLINIC - FI"/>
	Physician First Name: <input type="text"/>



# Subscriber – MyInfo Update Screen

**Identification:**

Member ID: [REDACTED]	Date of Birth: 07/11/1933
SSN: XXX-XX-X876	Date of Death:
Name: [REDACTED]	Marital Status: MARRIED
Gender: MALE	Marital Status Date: 07/20/1953
	Spouse ETF ID: 96315601411111120

Tax Dependent: YES  
Disabled: NO  
Begin Date: 01/01/2014  
End Date:  
Employee Type: LOCAL EMPLOYER PAID ANNUITANT  
Employment Status:

ETF's Insurance: SECONDARY  
Relationship: SELF  
Standard Plan Wait Indicator: NO  
Employer Resolution ID: 96732555235191114  
Previous Employer: 0991000

Other Health Insurance: NO

Medicare: YES

Medicare Eligibility Reason: AGE  
Health Insurance Claim Number: [REDACTED]  
Medicare A Effective Date: [REDACTED]  
Medicare B Effective Date: 01/01/2014

Medicare Info Blank Reasons:  
Select One  
Incomplete Information  
Survivor with Family1 Contract  
Other Non-State Primary Coverage  
Part B Declined  
Grandfathered Contract  
Federal Employee  
Not Eligible For Part A

Physician:  
National Provider ID: [REDACTED] Last/Clinic Name: DEAN CLINIC - F... Physician First Name: [REDACTED]







# Dependent – myInfo Update Screen (inquiry)

ETF Member ID: [REDACTED]	SSN: XXX-XX-X517	Subscriber: [REDACTED]	
Employer: MADISON, CITY OF P02/S01 \$1605.50	Health Plan: DEAN HEALTH PLAN	Coverage Level: FAMILY	Begin Date: 09/01/2000
<b>Identification:</b>			
Member ID: [REDACTED]	SSN: [REDACTED]	Name: [REDACTED]	Gender: MALE
Date of Birth: 09/09/1937	Date of Death:	Marital Status: MARRIED	Marital Status Date: 06/06/1964
Tax Dependent: YES	Disabled: NO	Begin Date: 09/01/2000	End Date: 12/31/2013
ETF's Insurance: SECONDARY	Relationship: SPOUSE	Standard Plan Wait Indicator: NO	
<b>Other Health Insurance:</b>			
PLAN	Insurance Company: DEAN HEALTH	Group Number: 18257	Policy Number: 390387264
<b>Medicare:</b>			
Medicare Eligibility Reason:	Medicare A Effective Date:	Medicare B Effective Date:	
Health Insurance Claim Number:	Medicare A Expiration Date:	Medicare B Expiration Date:	
Medicare Blank Reason:			
<b>Additional Medicare Info:</b>			
Medicare C Effective Date:	Medicare D Effective Date:	ESRD Start Date:	
Medicare C Expiration Date:	Medicare D Expiration Date:	ESRD End Date:	
Medicare C Contract No:	Medicare D Contract No:		
<b>Physician:</b>			



# Manage Retirement Screen

ETF Member ID:       SSN: XXX-XX-X517      Subscriber:

Employer: MADISON, CITY OF P02/S01 \$1605.50      Health Plan: DEAN HEALTH PLAN      Coverage Level: FAMILY

Employee Type	Employer	Coverage Level	Begin Date	End Date	Status	Health Plan
LOCAL EMPLOYEE	MADISON, CITY OF P02/S01 \$1605.50	FAMILY	09/01/2000	12/31/2013	ENDED	DEAN HEALTH PLAN
LOCAL EMPLOYER PAID ANNUITANT	MADISON, CITY OF P02/S01 \$1605.50	FAMILY	01/01/2014		PENDING	DEAN HEALTH PLAN

Row	Select	SSN	Member ID	Name	Birthdate	Gender	Relationship	Medicare A	Medicare B	HIC Number	Reason	Medicare Info	Blank Reason
1	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	12/30/1940	FEMALE	SELF	<input type="text"/>	<input type="text"/>	<input type="text"/>	Select One	Select One	
2	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	09/09/1937	MALE	SPOUSE	09/01/2002	09/01/2002	<input type="text"/>	AGE	Select One	Incomplete Information Survivor with Family1 Contract Other Non-State Primary Coverage Part B Declined Grandfathered Contract Federal Employee Not Eligible For Part A

  

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# Add Coverage Screen

ETF Member ID:  SSN: XXX-XX-X517 Subscriber:

Bypass Calculate Coverage Effective Date Edit

Add Coverage Reason:  Event Date:

Employer Received Date:

Employment Details:

Employer:  Program Option: P02 Surcharge: S01

Previous Employer: N/A Employment Begin Date:

Employee Type:  Employment Status: RETIRED

Coverage Selection:

Coverage Type:  Health Plan:  Effective Date: 01/01/2014

Contact Information:

Update Contact Information:  Country:

Address Line 1:  Address Line 2:  City:

State:  Zip Code:  Care of:  Primary Phone:  Ext:

Please verify the information listed below for yourself, and press the '+' button to add additional eligible dependents.

Row	SSN	Name - First, MI, Last, Suffix	DOB	Gender	Relationship	Marital Status	Marital Status Date	Tax Dep	Disabled	Physician	Add/Remove Row
1	<input type="text"/>	<input type="text"/>	<input type="text" value="12/30/1940"/> <input type="button" value=""/>	<input type="text" value="FEMALE"/>	<input type="text" value="SELF"/>	<input type="text" value="MARRIED"/>	<input type="text" value="06/06/1964"/> <input type="button" value=""/> (MM/DD/YYYY)	<input type="text" value="NO"/>	<input type="text" value="NO"/>		<input type="text" value="NO"/>

Insurance:  Other Insurance Co:  Group No:  Policy No:

Medicare:  Medicare:  Claim No:  Med A Eff Dt:   Med B Eff Dt:   Medicare Info Blank Reasons:

- Incomplete Information
- Survivor with Family I Contract
- Other Non-State Primary Coverage
- Part B Declined
- Grandfathered Contract
- Federal Employee
- Not Eligible For Part A



# Change Health Plan Screen

ETF Member ID:  SSN: XXX-XX-X357 Subscriber:   
 Employer: MADISON, CITY OF P02/S01 \$1160.60 Health Plan: DEAN HEALTH PLAN Coverage Level: MEDICARE - FAMILY 1

Reason for Changing Health Plan:  Select One Event Date:  MM/DD/YYYY  
 Employer Received Date:  MM/DD/YYYY

You are requesting a change in health plan for member and all dependents.

Health Plan	Coverage Level	Begin Date	End Date	Status	Employer
DEAN HEALTH PLAN	MEDICARE - FAMILY 1	01/01/2014		PENDING	MADISON, CITY OF P02/S01 \$1160.60
<input type="text"/>	MEDICARE - FAMILY 1			PENDING	MADISON, CITY OF P02/S01 \$1160.60

Row	SSN	Name - First, MI, Last, Suffix	DOB	Gender	Relationship	Tax Dep	Disabled	Other Hlth Ins/Medicare	Physician
1	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	11/16/1939	FEMALE	SELF	YES	NO	YES	YES
Insurance: <input type="text"/> NO Other Insurance Co: <input type="text"/> Group No: <input type="text"/> Policy No: <input type="text"/> Medicare: <input type="text"/> YES Medicare: <input type="text"/> AGE Claim No: <input type="text"/> Med A Eff Dt: <input type="text"/> Med B Eff Dt: 01/01/2014 Medicare Info Blank Reasons: <input type="text"/> Select Physician Info - National Provider Id: <input type="text"/> Physician Last/Clinic Name: DEAN CLINIC First Name: <input type="text"/>									
2	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	11/17/1938	MALE	SPOUSE	YES	NO	Select One	YES
Physician Info - National Provider Id: <input type="text"/> Physician Last/Clinic Name: DEAN CLINIC First Name: <input type="text"/>									