AmeriHealth NEW JERSEY

Please Mail To:
AmeriHealth New Jersey
259 Prospect Plains Road, Building M,
Cranbury, NJ 08512

AmeriHealth New Jersey Small Group Member Coverage Application

AmeriHealth New Jersey	Group Information – to be completed by Employer:		
AmeriHealth New Jersey	Group Name:	Group Number:	Class Code:

A. Type of Activity – To be completed by Applicant. *Refer to instructions before completing this form. Print clearly.*

	Activity – Check all that apply	Date of Event	Date of Hire/Reason for Change
ADD	☐ Enrollment of a new Subscriber	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Spouse	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Civil Union Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Domestic Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Dependent Child	___/___/___	Date:___/___/___ Reason:_____
	☐ Add Over-Age Child as a Dependent Under 31 *(and complete Coverage Continuation section)*	___/___/___	Date:___/___/___ Reason:_____
REMOVE	☐ Employee Withdrawal/Termination	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Spouse	___/___/___	Date:___/___/___ Reason:_____
	☐ Civil Union Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Domestic Partner	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Dependent Child	___/___/___	Date:___/___/___ Reason:_____
	☐ Remove Over-Age Child as a Dependent Under 31	___/___/___	Date:___/___/___ Reason:_____
OTHER CHANGES	☐ Name Change	___/___/___	_____
	☐ Change Plan	___/___/___	_____
	☐ Other	___/___/___	_____
	☐ Add/Change Office ID Numbers: Primary/OB/Gyn/Dentist **See list of Triggering Events in Instructions*	___/___/___	_____

COVERAGE CONTINUATION	☐ For Employee	☐ Total Disability* ☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 29	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___
	Billing: ☐ Group ☐ Home (Section B)					***Attach proof of disability**
	☐ For Spouse/Civil Union Partner*	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___	
	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section E			***Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.**		
	☐ For Dependent/ Over-age Child	☐ COBRA/NJSGC	Length of Continuation (in months): ☐ 18 ☐ 36	Date of Loss of Coverage: ___/___/___	Qualifying Event #: _____**	Date of Qualifying Event: ___/___/___
	☐ Dependent Under 31	Qualifying Event #: _____**	Billing: ☐ Group ☐ Home (what address?) ☐ Section B OR ☐ Section F			
	****Qualifying event #s: see list in Instructions. ***Billing through the group for a Dependent Under 31 Continuation Election requires agreement by the employer at Section J.**					

B. Employee Information – To be completed by the Employee

Name (Last, First, MI):	SSN:	Birthdate (mm/dd/yyyy)	Sex: ☐ M ☐ F

HOME	Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Phone:_____ Email: _____
WORK	Employer Name:_____ Address:_____ City, State, Zip Code:_____ Phone:_____ Email: _____ Employment Date: _____ Hours worked per week: _____

ACTIVITY	☐ Add ☐ Remove ☐ Continuation ☐ Other Change – *If a name change, indicate prior name:*		
	Primary Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Ob/Gyn Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:
	Dentist Loc #:	NPI or PCP ID #:	Current Patient: ☐ Yes ☐ No
	Address:		Zip+4:

Other Health Coverage? ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____	Other Rx Coverage? ☐ Yes ☐ No If yes: Payer Name: _____ Policy #: _____ Medicare ID#, if any: _____
C. Plan Option – to be completed by the Employee	Medical Plan Name:

D. Other Individuals Covered – to be completed by the Employee *Identify individuals other than yourself for whom you are adding/changing removing coverage. Attach additional pages if necessary, dated and signed by you. Attach proof of disability if necessary.*

1.Spouse/Domestic Partner/ Civil Union Partner	2. Child	3. Child	4. Child
☐ Add ☐ Remove ☐ Other ☐ Continue Spouse ☐ Continue CU Partner (NJSGC)	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue	☐ Add ☐ Remove ☐ Other ☐ Continue
Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:	Name (last, first, MI) L:_____ F:_____ MI:
Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___	Birthdate (mm/dd/yyyy):___/___/___
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
SSN:	SSN:	SSN:	SSN:
Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other health coverage ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____	Other Rx Coverage: ☐ No ☐ Yes – If Yes: Payer Name: _____ Policy #: _____ Medicare ID #: _____
Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Primary Care Provider: NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No
Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA	Ob/Gyn Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No ☐ NA
Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No	Dentist Office NPI or PCP ID #: _____ Address: _____ _____ _____ Current Patient? ☐ Yes ☐ No

Employed? ☐ Yes ☐ No *If yes, complete Section E1*	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____	If last name is different from Employee's, please explain: _____ _____
Home or billing address same as Employee? ☐ Yes ☐ No *If NO, complete Section E2*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*	Living with Employee? ☐ Yes ☐ No *If NO, complete Section F*

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – to be completed by Employee. *If not applicable, please mark as "NA."*

1.	Employer Name:_____ Employer Address:_____ City, State, Zip Code:_____ Phone:_____
2.a	Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____
2.b	Please explain why the address is different:_____ _____ _____

F. Additional Child Information – to be completed by Employee. *Provide information below about children listed in Section D,* ***if*** *they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.*

Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____	Name(s):_____ Street/Apt:_____ Street/Apt:_____ City, State, Zip Code:_____ Reason:_____

G. Race/Ethnicity – to be completed by Employee at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic ☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

H. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature:	Date:____/____/____

I. Over-Age Child's Signature

I represent that all the information supplied in this application regarding the Dependent Under 31 Continuation Election is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I hereby agree to make contributions required from me for the Dependent Under 31 Continuation Election

Signature:	Date:____/____/____

J. Employer Verification

The requested activity is believed eligible and is approved by the Employer. In addition, the Employer consents to payroll deduction for Dependent Under 31 Continuation Election: ☐ Yes ☐ No

Employer Representative:	Date:____/____/____
Representative's Title:	

INSTRUCTIONS

Employers – You must complete the Employer Group Information and sections A and J in order for this application to be processed.

Employees – You must complete sections B through H and submit the signature of each Over-Age Child for which a Dependent Under 31 Continuation Election is made in accordance with Section I in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond age 26, you do not have to make a COBRA/NJSGC or Dependent Under 31 election. Instead, select "Other" in Section A3, and attach proof of disability.
- For provider addresses, include the zip code plus the four digit extension (9 digits)
- You can obtain the providers' correct names and addresses from the appropriate provider directory. You may also obtain each provider's NPI or PCP ID number from the provider directory on www.amerihealthnj.com or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI or PCP ID number. You should confirm the correct NPI or PCP ID number for the specific provider and office location where you will be seen by contacting that office directly.

Qualifying Events

COBRA and NJSGC

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

Dependent Under 31

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage

CONDITIONS OF ENROLLMENT – APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give AmeriHealth New Jersey, or any consumer reporting agency acting on behalf of AmeriHealth New Jersey, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that AmeriHealth New Jersey has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree AmeriHealth New Jersey will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

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Language Taglines and Nondiscrimination Notice

Language Access Services

This Notice has Important Information. This notice has important information about your application or coverage through AmeriHealth New Jersey. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-888-968-7241 TTY 711.

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de AmeriHealth New Jersey. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-888-968-7241 TTY 711.

本通知含有您的申请或 AmeriHealth New Jersey 提供的健康保险信息等重要信息。请留意本通知内的重要日期。为了保留您的健康保险或得到收费相关支持，请在截止日期之前采取措施。相关咨询请联系我们为您提供的免费多语言信息服务，1-888-968-7241。

본 알림에는 귀하의 신청 또는 AmeriHealth New Jersey 를 통한 건강 보험과 관련된 정보와 같은 중요한 정보가 포함되어 있습니다. 본 알림에서 중요한 날짜를 확인하십시오. 지정된 마감일까지 조치를 취하셔야 건강 보험을 계속해서 유지하거나 비용 관련 지원을 받으실 수 있습니다. 관련 정보 및 지원은 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-888-968-7241 로 전화해 주십시오.

Este aviso contém informações importantes. Este aviso contém informações importantes a respeito do seu formulário de solicitação ou cobertura por meio do AmeriHealth New Jersey. Procure as datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter a cobertura do seu plano de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 1-888-968-7241.

આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં તમારી અરજી અથવા AmeriHealth New Jersey દ્વારા કવરેજ વિશેની અગત્યની માહિતી છે. આ સૂચનામાંની ખાસ તારીખો જુઓ. તમે તમારા આરોગ્ય કવેરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવા માટે અમુક ચોક્કસ મુદતો સુધીમાં પગલાં લેવાની જરૂર છે. તમને આ માહિતી અને મદદ તમારી ભાષામાં વિના મૂલ્યે મેળવવાનો અધિકાર છે. અહીં 1-888-968-7241 કોલ કરો.

To ogłoszenie zawiera ważne informacje. To ogłoszenie zawiera ważne informacje dotyczące Państwa wniosku lub zakresu świadczeń udzielanych przez program AmeriHealth New Jersey. Powinni Państwo podjąć działania do czasu upłynięcia wyznaczonych terminów, aby utrzymać swoje ubezpieczenie zdrowotne bądź otrzymać pomoc związaną z kosztami. Mają Państwo prawo do bezpłatnej informacji we własnym języku. Proszę zadzwonić pod numer 1-888-968-7241.

Questo avviso contiene informazioni importanti . Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso AmeriHealth New Jersey. Cerca le date importanti in questo avviso. Potrebbe essere necessario un tuo intervento entro certe scadenze determinate per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere gratuitamente queste informazioni e assistenza nella tua lingua. Chiama il numero 1-888-968-7241.

يحوي هذا الإشعار معلومات هامة. يحوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال AmeriHealth New Jersey. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل بـ 1-888-968-7241.

(OVER)

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Ang Paunawang ito ay may Mahalagang Impormasyon. Ang paunawang ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o saklaw sa pamamagitan ng AmeriHealth New Jersey. Tingnan ang mahahalagang petsa sa paunawang ito. Maaaring kailanganin mo na magsagawa ng hakbang bago ang mga tiyak na takdang panahon upang mapanatili ang iyong saklaw pangkalusugan o tulong sa mga gastos. May karapatan kang makakuha ng impormasyon at tulong na ito sa iyong wika nang walang gastos. Tumawag sa 1-888-968-7241.

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через программу AmeriHealth New Jersey. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры до наступления определенных предельных сроков для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-888-968-7241.

Avi sa a gen Enfòmasyon Enpòtan ladan. Avi sa a gen enfòmasyon enpòtan konsènan aplikasyon ou, oswa pwoteksyon asirans ou nan AmeriHealth New Jersey. Chèche dat kle yo ki nan avi sa a. Ou kapab bezwen aji avan sèten delè pou kontinye genyen pwoteksyon asirans sante ou oswa resevwa èd gratis. Ou gen dwa pou jwenn enfòmasyon sa a ak èd ou bezwen nan lang ou gratis. Rele 1-888-968-7241.

इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या AmeriHealth New Jersey के माध्यम से बीमे के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या लागतों में मदद के लिए आपको कुछ निश्चित समयसीमाओं तक कार्रवाई करने की ज़रूरत हो सकती है। आपको यह जानकारी और सहायता अपनी भाषा में मुफ्त प्राप्त करने का अधिकार है। 1-888-968-7241 पर कॉल करें।

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm thông qua AmeriHealth New Jersey. Hãy tìm những ngày quan trọng trong thông báo này. Quý vị có thể cần thực hiện hành động trước một số thời hạn để duy trì bảo hiểm y tế hoặc trợ giúp về chi phí. Quý vị có quyền nhận được thông tin và trợ giúp bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Hãy gọi số 1-888-968-7241.

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou l’assurance médicale fournie par AmeriHealth New Jersey. Recherchez les dates clés dans le présent avis. Vous devez peut-être agir dans des délais spécifiques pour maintenir votre assurance médicale ou pour l'aide avec les coûts. Vous avez le droit d'obtenir gratuitement cette information et de l’aide dans votre langue. Appelez 1-888-968-7241.

اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں آپ کی درخواست اور AmeriHealth New Jersey کے ذریعے احاطہ کردہ خدمات کے بارے میں اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں پر دھیان دیں۔ آپ کو اپنے طبی تحفظ کو برقرار رکھنے یا اخراجات کے حوالے سے مدد کے لئے کچھ ڈیڈلائنوں کے اندر کاروائی کرنے کی ضرورت ہو سکتی ہے۔ آپ کو بلا معاوضہ اپنی زبان میں یہ معلومات اور مدد حاصل کرنے کا حق ہے۔ 1-888-968-7241 پر کال کریں۔

Díí saad ílínii baa hane’. Naaltsoos ni’íníłtsoozígíí éí doodago kwe’é AmeriHealth New Jersey nik’é’ésti’ígíí bína’ídółkidgo díí kwe’é hazhó’ó baa ákonínízin dooleeł. Yoołkáał yę́édą́ą’ nich’į’ é’élyaago biká’ígíí hádídíí’įįł. Díí niké’ésti’ígíí éí doodago béeso da bee níká a’doowołígíí bikáa’go da áat’ée dooleeł áko t’áadoo bee e’e’aahí baa yółkaahgo tsxíįłgo hasht’e díílíił nii da dooleeł.Bee ná ahóót’i’díí kót’éego yaa halne’ígíí bee níká a’doowołgo dóó t’áá nizaadk’ehjí bee nił hodoonih t’áadoo bą́ą́h ílíní. Kojį’ hodíílnih 1-888-968-7241.

この通知には、AmeriHealth New Jersey の申請や補償範囲に関するとても重要な情報が含まれています。ここに記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期限までに行動を取る必要があります。お客様は、無料でご希望の言語でのサポートや情報を入手することができます。
ぜひ 1-888-968-7241 までお電話ください。

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AmeriHealth NEW JERSEY

Diese Bekanntmachung enthält wichtige Informationen. Diese Bekanntmachung enthält wichtige Informationen über Ihren Antrag bei oder Ihren Krankenversicherungsschutz durch AmeriHealth New Jersey. Beachten Sie bitte die wichtigsten Termine in dieser Bekanntmachung. Sie müssen eventuell vor bestimmten Stichtagen Maßnahmen ergreifen, um Ihren Krankenversicherungsschutz nicht zu verlieren oder finanzielle Unterstützung für diese Leistungen zu erhalten. Sie sind berechtigt, kostenlos Hilfe und weitere Informationen in Ihrer Sprache anzufordern. Bitte rufen Sie uns unter der Nummer 1-888-968-7241 an.

این اطلاعیه حاوی اطلاعاتی مهمی است. این اطلاعیه حاوی اطلاعات مهمی درباره درخواست شما یا قرارگیری تحت پوشش AmeriHealth New Jersey می باشد. به تاریخ های مهم مندرج در این اطلاعیه توجه نمایید. ممکن است لازم باشد به منظور ادامه استفاده از پوشش خدمات سلامت یا کمک در رابطه با کاهش هزینه ها، اقدامات مربوطه را تا قبل از تاریخ خاصی صورت دهید. این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. با شماره 1-888-968-7241 تماس بگیرید

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

AmeriHealth 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. AmeriHealth New Jersey does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth 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 our Civil Rights Coordinator. If you believe that AmeriHealth 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, yo can file a grievance with our Civil Rights Coordinator. You have four ways to file a grievance:

- By mail :
  AmeriHealth New Jersey
  Attn: Civil Rights Coordinator
  1901 Market Street
  Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY:711)
- By fax: 215-761-0245
- By email: CivilRightsCoordinator@amerihealth.com

If you need help filing a grievance, our Civil Rights Coordinator 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.j* 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*.

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