ASSURITY DCE, LLC

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in a Direct Contracting Entity (DCE), to work together with Medicare to give you more coordinated care and services.

PROVIDER is voluntarily taking part in this new initiative by joining Assurity DCE, LLC because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional think that you might benefit from care coordination and preventive services offered by Assurity DCE, LLC.

Through improved care coordination and preventive services, Assurity DCE, LLC and its health care providers are committed to providing better care, better health and lower costs.

You can use this form to confirm that PROVIDER is the main doctor or other health care professional you see or the main place you go for routine care, to help determine if Assurity DCE, LLC should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension. **Please complete and return the enclosed form in the envelope provided by [$RETURNDATE].**

Alternatively, instead of returning this form, you can also log into MyMedicare.gov and select your main doctor or other health care professional in order to determine whether Assurity DCE, LLC should help with coordinating your care. Instructions for navigating MyMedicare.gov are included with this letter. If you make a selection on this form and make a different selection through MyMedicare.gov, Medicare will prioritize the selection you make through MyMedicare.gov.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.
Whether or not you complete this form or select a doctor or other health care professional through MyMedicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call Assurity DCE, LLC at 813-533-0591, or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about DCEs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through MyMedicare.gov is your choice AND you can change your mind.
If you choose to complete this form or select a doctor or other health care professional through MyMedicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through MyMedicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

ASSURITY DCE, LLC

Please call 813-533-0591 or update your online selection if you change your mind later about whether you consider PROVIDER to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,

Paola Bianchi Delp, MBA. MHA, ACHE
President
Assurity DCE

Get more information about DCEs.

CMS Website: https://innovation.cms.gov/initiatives/direct-contracting-model-options

DCE Website: www.AssurityDCE.com

ASSURITY DCE, LLC

CONFIRMATION OF MAIN DOCTOR OR OTHER HEALTHCARE PROFESSIONAL FORM

1. CONFIRM ✓

By signing below I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is [$PROVNAME AND/OR $MEDICALGROUP].

Printed Name

_____ _____

Signature **Print Name**

___ /__ /2022

Date

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call [$DCENAME] at [$DCENUMBER] to request a new form.

2. RETURN ✉

Return this form in the envelope that we provided.

[DCE may include additional instructions for returning this form to the DCE]

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.