

2018 MassHealth SCO Medicare Advantage Enrollment Request Form

Please contact UnitedHealthcare® Senior Care Options (HMO SNP) if you need this information in another language or format (Braille).

This form is for people who have MassHealth Standard (Medicaid) benefits and choose to enroll in UnitedHealthcare® Senior Care Options (HMO SNP). You must also have Medicare Parts A and B.

If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our SCO program.

MassHealth Standard (Medicaid) information.

Are you enrolled in MassHealth? Yes No

Please write your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name.

MassHealth ID Number __/__/__/__/__/__/__/__/__/__/__/__

You must have MassHealth Standard benefits to enroll in a senior care organization. To apply for MassHealth, call 1-888-834-3721 (TTY 1-800-497-4648 for people with partial or total hearing loss).

Information about you (please type or print in black or blue ink).

<input type="checkbox"/> Mr.	Last Name	First Name	Middle Initial
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			

Birth Date MM/DD/YYYY	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Main Phone Number () -	Other Phone Number () -
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Name of Skilled Nursing Facility (if applicable)

Permanent Street Address
(not a PO box)

City	County	State	ZIP Code
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Mailing Address (Only if it's different from above.
You can give a PO box.)

City	County	State	ZIP Code
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Email Address

Enrollee's Name _____

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Information about your Medicare.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled to _____ Effective Date _____

Hospital (Part A) _____

Medical (Part B) _____

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

A few questions to help us manage your plan.

1. Do you want plan information in another language or format? Yes No

Please check what you'd like: Spanish Other

Please contact UnitedHealthcare® SCO (HMO SNP) at 1-888-834-3721 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m. local time, 7 days a week. TTY users should call 711.

2. Do you have end-stage renal disease? Yes No

Generally, if you answered "yes" to this question, you cannot enroll in SCO. However, if you have had a successful kidney transplant and/or you don't need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

Please read this important information.

If I have health coverage from an employer or union now, I could lose my employer or union health coverage if I join UnitedHealthcare® SCO (HMO SNP). I will read the communications my employer or union sends me. If I have questions, I will visit the website or I will call my benefits administrator or the office who answer questions about my employer or union coverage.

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3. Do you or your spouse work? Yes No

Do you or your spouse have other health insurance that will cover medical services? Yes No
(Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits)

If yes, please complete the following:

Name of Health Insurance _____

Company _____

Subscriber Name _____ Group ID _____

Member ID _____ Effective Dates (if applicable) _____

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to SCO and MassHealth (Medicaid)?

Yes No

If you answered "yes," what is the name of the other insurance?

Name of other insurance _____

ID# for this coverage _____ Group# for this coverage _____

4. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the provider directory.

Provider or PCP full name _____ Phone number (_____) _____ - _____

Provider/PCP ID number

(Please enter the number exactly as it appears on the website or in the directory. It will be 10 to 12 digits. Don't include dashes.)

Please read and sign below.**By completing this enrollment form, I agree to the following:**

This senior care organization, UnitedHealthcare® SCO (HMO SNP), is a Medicare Advantage plan and has a contract with the Federal government. UnitedHealthcare® SCO (HMO SNP) also has a contract with the Commonwealth of Massachusetts/MassHealth. This is not a Medicare Supplement Plan. I will need to keep my MassHealth Standard. I will also need to keep my Medicare Part A and Part B if I am eligible. I can be in only one Medicare Advantage or Prescription Drug plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. If I have prescription drug coverage, or if I get prescription drug coverage, from somewhere other than this plan, I will inform the plan. Because I have MassHealth, I may leave UnitedHealthcare® SCO (HMO SNP) at any time. I will no longer be covered by UnitedHealthcare® SCO (HMO SNP) on the first day of the month following the month I request to leave UnitedHealthcare® SCO (HMO SNP). (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

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UnitedHealthcare® SCO (HMO SNP) serves a specific service area. If I move out of the area that UnitedHealthcare® SCO (HMO SNP) serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of UnitedHealthcare® SCO (HMO SNP), I have the right to appeal plan decisions about payment or services if I disagree with them. I will read the Evidence of Coverage from UnitedHealthcare® SCO (HMO SNP) when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare/Medicaid beneficiaries are generally not covered under Medicare/Medicaid while out of the country with certain exceptions.

I understand that beginning on the date that UnitedHealthcare® SCO (HMO SNP) coverage begins, I must get all my health care from UnitedHealthcare® SCO (HMO SNP) with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by UnitedHealthcare® SCO (HMO SNP) and other services contained in my UnitedHealthcare® SCO (HMO SNP) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare, MassHealth, nor UnitedHealthcare® SCO (HMO SNP) will pay for the services.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with UnitedHealthcare® Services, Inc., he or she may be compensated based on my enrollment in UnitedHealthcare® SCO (HMO SNP).

Release of information: By joining UnitedHealthcare® Senior Care Options (HMO SNP) (UnitedHealthcare® SCO), I acknowledge that UnitedHealthcare® SCO will release my information to Medicare/MassHealth and other plans or providers as is necessary for treatment, payment and health care operations. I also acknowledge that UnitedHealthcare® SCO (HMO SNP) will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. 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 my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (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 UnitedHealthcare® SCO (HMO SNP) or by Medicare. One of our Enrollee Service Representatives will be calling you to verify the information on this form and to make sure you understand our plan rules.

Please provide a phone number we may use for that call (_____) _____ - _____
 Best Time to Call: Morning Afternoon Evening

Signature of applicant/member/authorized representative

Today's Date

MM/DD/YYYY

Enrollee's Name _____

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If you are the authorized representative, you must sign above and provide the following information.

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number () -		
Relationship to Applicant		

For sales representative/agency use only.

Licensed Sales Representative/Writing ID	Initial Receipt Date MM/DD/YYYY
Licensed Sales Representative/Agent Name	Proposed Effective Date MM/DD/YYYY
Licensed Sales Representative Phone Number () -	

Where did this application originate?

- Retail/Mall Program Community Meeting Member Meeting
 Local B2B Outreach Local Event Outreach Other

How was this application submitted?

- Appointment Other Mail-in

Agent must complete

- AEP ICEP (MA enrollees) IEP (MA-PD enrollees) IEP (MA-PD enrollees
 OEPI SEP (Chronic) SEP (Full Dual Eligible) eligible for 2nd IEP)
 SEP (Partial SEP (SEP Reason) _____
 Dual Eligible)
 SEP Eligibility Date MM/DD/YYYY

Licensed Sales Representative Signature

Enrollee's Name _____

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UnitedHealthcare SCO is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare. If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our SCO program.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call **1-888-834-3721**, TTY **711**, daily, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al **1-888-834-3721** (TTY: **711**).

ATENÇÃO: Caso fale português, serviços de intérprete estão disponíveis sem custo para você. Ligue para **1-888-834-3721** (TTY: **711**).