



2020 MassHealth SCO Medicare Advantage Enrollment Request Form

UnitedHealthcare® Senior Care Options (HMO D-SNP) H2226-001

This plan is for seniors over age 65, who are enrolled in Medicare Part A and B and MassHealth Standard coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus) and Specified Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) aged 65 or older and with MassHealth Standard coverage.

UnitedHealthcare® Senior Care Options NHC (HMO D-SNP) H2226-003

This plan is for seniors over age 65, who are enrolled in Medicare Part A and B and MassHealth Standard coverage who reside in an institution or who are in the community but receive home and community-based support services because they have functional deficits. These services help persons who normally qualify for a nursing home (Nursing Home Certifiable) to remain safely at home.

Please contact UnitedHealthcare® Senior Care Options 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. 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 UnitedHealthcare® SCO program.

MassHealth Standard (Medicaid) information.

Are you enrolled in MassHealth? Yes No

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

MassHealth 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	
Daytime Phone Number () -		Mobile Phone Number () -	

Enrollee's Name _____

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Name of Skilled Nursing Facility (if applicable)

Permanent Street Address (**not a P.O. Box**)

City	County	State	ZIP Code
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Mailing Address (**Only if it's different from above. You can give a P.O. Box.**)

City	County	State	ZIP Code
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Email Address

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: _____

Sex: _____

Is Entitled to: Effective Date:

Hospital (Part A) **MM-DD-YYYY**

Medical (Part B) **MM-DD-YYYY**

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

Enrollee's Name _____

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A few questions to help us manage your plan.

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

Please check what you'd like: Spanish Other

Please contact UnitedHealthcare® SCO toll-free 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., 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 UnitedHealthcare® 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. 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.

3. Do you or your spouse work? Yes No

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

If yes, please complete the following:

Name of Health Insurance Company _____

Subscriber Name		Group Number
Member Number	Effective Dates (if applicable) MM-YYYY - MM-YYYY	

4. 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 UnitedHealthcare® SCO and MassHealth (Medicaid)? Yes No

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

Name of Other Insurance _____

Member Number	Group Number	Date Plan Started MM-DD-YYYY
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Enrollee's Name _____

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Release of information: By joining UnitedHealthcare® Senior Care Options (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 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 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

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

***NOT A SALES AGENT**

Last Name

First Name

Address

City

State

ZIP Code

Phone Number

Relationship to Applicant

(_____) _____ - _____

Enrollee's Name _____

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For sales representative/agency use only.

Licensed Sales Representative/Writing ID @AGENTID@	Initial Receipt Date MM-DD-YYYY
Licensed Sales Representative/Agent Name @AGENTFULLNAME@	Proposed Effective Date MM-DD-YYYY
Licensed Sales Representative Phone Number @AGENTPHONE@	

Where did this application originate?

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

How was this application submitted?
 Mail
 Fax
 Online

Agent must complete

- | | |
|---|--|
| <input type="checkbox"/> IEP (MA-PD Enrollee) | <input type="checkbox"/> ICEP (MA Enrollees) _____ |
| <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2nd IEP) | <input type="checkbox"/> OEP (Jan 1 – Mar 31) |
| <input type="checkbox"/> OEP (newly eligible) | <input type="checkbox"/> SEP (Dual LIS change of status) |
| <input type="checkbox"/> SEP (Change in residence) | <input type="checkbox"/> SEP (Loss of EGHP coverage) |
| <input type="checkbox"/> SEP (Chronic) | <input type="checkbox"/> SEP (Dual LIS maintaining) |
| <input type="checkbox"/> AEP (October 15 – December 7) | <input type="checkbox"/> OEPI |
| <input type="checkbox"/> SEP (SEP Reason) _____ | <input type="checkbox"/> SEP Eligibility Date MM-DD-YYYY |

Licensed Sales Representative Signature

Date

MM-DD-YYYY

Please mail or fax completed form to:

ATTN: Enrollment Department
 950 Winter Street, Suite 3800
 Waltham, MA 02451
 1-855-250-2168

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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**).

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