2021 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.

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).

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date MM-DD-YYYY	Sex: ☐ Male ☐ 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

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

City	County	State	ZIP Code

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.

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.

2. 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

3. 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

Enrollee's Name ______________________________

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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 number:

(Please enter the number exactly as it appears on the website or in the Provider 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, is a Medicare Advantage plan and has a contract with the Federal government. UnitedHealthcare® SCO 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 must keep both Part A and Part B to stay in UnitedHealthcare® SCO. I can be in only one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan. If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan. Because I have MassHealth, I may leave UnitedHealthcare® SCO at any time. I will no longer be covered by UnitedHealthcare® SCO on the first day of the month following the month I request to leave UnitedHealthcare® SCO. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.) UnitedHealthcare® SCO serves a specific service area. If I move out of the area that UnitedHealthcare® SCO 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, I have the right to appeal plan decisions about payment or services if I disagree with them.

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I understand that when my UnitedHealthcare® SCO coverage begins, I must get all my medical and prescription drug benefits from UnitedHealthcare® SCO. Benefits and services authorized by UnitedHealthcare® SCO and other services contained in my UnitedHealthcare® SCO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare, MassHealth, nor UnitedHealthcare® SCO will pay for the benefits or 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.

Enrollee's Name ____________________

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Release of information: By joining this Medicare Advantage or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans 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 which 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 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.

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	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
☐ Appointment ☐ Local Event Outreach ☐ Other

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

Agent must complete

☐ IEP (MA-PD Enrollee)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEP (newly eligible)
☐ SEP (Change in residence)
☐ SEP (Chronic)
☐ AEP (October 15 – December 7)
☐ SEP (SEP Reason) ________________________
☐ ICEP (MA Enrollees) ______________________
☐ OEP (Jan 1 – Mar 31)
☐ SEP (Dual LIS change of status)
☐ SEP (Loss of EGHP coverage)
☐ SEP (Dual LIS maintaining)
☐ OEPI
☐ SEP Eligbility 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

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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