MassHealth

2022 MassHealth SCO Medicare Advantage enrollment request form

☐ **UnitedHealthcare® Senior Care Options (HMO D-SNP) H2226-001-000**

☐ **UnitedHealthcare® Senior Care Options NHC (HMO D-SNP) H2226-003-000**

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)

Last Name	First Name	Middle Initial
Birth Date	Sex: ☐ Male ☐ Female	
Home Phone Number ( ) –	Mobile Phone Number ( ) –	

Name of Skilled Nursing Facility (if applicable)	Medicare Number

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

City	County	State	ZIP Code

Enrollee's Name ______________________________

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

City	State	ZIP Code

Email Address (optional)

Will you have other prescription drug coverage in addition to UnitedHealthcare® SCO and MassHealth (Medicaid)? ☐ **Yes** ☐ **No**

(Examples: other private insurance, TRICARE, Federal employee heath benefits coverage, VA Benefits, or State programs.)

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

Name of Other Insurance

Member Number	Group Number
Rx Bin	Rx PCN (optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

A few questions to help us manage your plan

1. Would you prefer plan information in another language or an accessible format? ☐ **Yes** ☐ **No**

Please check what you'd like: ☐ Spanish ☐ Braille ☐ 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 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

Member Number

Enrollee's Name ______________________________

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3. 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

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. Because I have MassHealth, I may leave UnitedHealthcare® SCO if I have a qualifying election period. 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. 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.

I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.

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.**

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.

Estate Recovery Awareness: MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit: www.mass.gov/estaterecovery.

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 to Federal law that authorize the collection of this information (see Privacy Act Statement below). My response to this form is voluntary. However, failure to respond may affect enrollment in the plan. The information on this 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.

When I sign below, it means that I have read and understand the information on this form. If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

Signature of applicant/member/authorized representative	**Today's Date**

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
Licensed Sales Representative/Agent Name	Proposed Effective Date

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

Licensed Sales Representative Signature ____________________ **Date**

Please mail or fax completed form to:
ATTN: Enrollment Department
950 Winter Street, Suite 3800
Waltham, MA 02451
1-855-250-2168

Enrollee's Name ______________________________

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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**).

Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

- ✔ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Call us or go online to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✔ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✔ Review the Pharmacy Provider Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✔ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ✔ Benefits may change on January 1 of each year. UnitedHealthcare Senior Care Options members have a $0 premium/copays/coinsurance.
- ✔ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ✔ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.
- ✔ This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. To qualify, you must be 65 or older, be eligible to receive Medicare Part A, and be enrolled in Medicare Part B and MassHealth Standard. You may also need to live in your own home or a nursing facility. If you have MassHealth Standard, but you do not qualify for Medicare Part A and/or Medicare Part B, you may still be eligible to enroll.