





2024 MassHealth SCO Medicare Advantage Enrollment Request Form

Request I of III			
☐ UHC Senior Care Options MA-Y☐ UHC Senior Care Options NHC	•	•	000
This form is for people who have Ma UnitedHealthcare® Senior Care Opt If you have MassHealth Standard, b eligible to enroll in our MassHealth benefits through our UnitedHealthca	cions. You must a out you do not qu Senior Care Opti	lso have Medicare Pa alify for Original Medio on plan and receive a	rts A and B. care, you may still be
MassHealth Standard (Medi	icaid) Informa	tion	
Are you enrolled in MassHealth? Please write your MassHealth numnumber is the 12-digit number und MassHealth Number You must have MassHealth Standfor MassHealth, call 1-888-834-3 hearing loss).	ber or attach a c ler your name. dard benefits to	opy of your MassHeal	e organization. To apply
Information about you (Pleas	e type or print in	black or blue ink)	
Last name	First name		Middle initial
Birth date		Sex □ Male □ Fer	nale
Home phone number () -		Mobile phone number () -	
Social Security number (Required for people who are enro	lling in D-SNP pla	ans):	-
Name of skilled nursing facility (if a	applicable)		
Medicare number			
Permanent residence street addres	ss (P.O. box is n	ot allowed)	
Enrollee name			

Agent name/ID number _ H2226_ERF_2024_C UHCSCO_ERF_H2226_2024

City	County	State	ZIP code
Mailing address (Only if	f it's different from above. Yo	ou can give a P.O. bo	x.)
City		State	ZIP code
Email address (optional)		
Do you have other insur	rance that will cover your pre	escription drugs?	☐ Yes ☐ No
programs.)	insurance, TRICARE, federal	employee coverage, \	VA benefits or state
If yes, what is it? Name of other insurance	 e		
Member number	Group number	RxBin	RxPCN (optional)
			(0)
If you don't see the lar	u'd like: □ Spanish □ Braille [nguage or format you want, pl al time, 7 days a week. Or visi	ease call us toll-free a	
No, not of Hisp Yes, Mexican, I Yes, Puerto Ric Yes, Cuban	ispanic, Latino, or Spanish ori	gin o/a	
			CSMA24HM0133956_000

3. What's your race? Select all	that apply.		
White	Black or A	African American	
American Indian or Ala	ska Native		
Asian Indian	Chinese		Filipino
Japanese	Korean		Vietnamese
Other Asian	Native Ha	waiian	Samoan
Guamanian or Chamo	rro Other Pac	cific Islander	
I choose not to answe	•		
Member/Citizen of a fo	ederal or state reco	gnized Tribe (name	of Tribe)
4. Do you or your spouse work	?		☐ Yes ☐ No
Do you or your spouse have o	ther health insurance	e that will cover me	edical services?
(Examples: Other employer gr			
auto liability, or Veterans bene			☐ Yes ☐ No
If yes, please complete the fol	•		
Name of health insurance co	mpany		
Member number			
Welliger Hamber			
5. Please give us the name of y You can find a list on the plan Provider or PCP full name		• •	
Provider/PCP number:	(Please enter the nu	mber exactly as it appears
			the Provider Directory. It will
			on't include dashes.)
Are you now seeing or have yo	ou recently seen this	s provider? Li Ye	es 🗆 No
Enrollee name			
Agent name/ID number			
Tychi Hame/ ID Humber			

Please read and sign

By completing this 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 plan. I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one,
unless Medicaid or someone else pays for it.
□ 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 coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
□ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private-Fee-For-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).
□ Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
☐ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
☐ I give consent for all entities under UnitedHealthcare and its affiliates and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided using an autodialer and/or prerecorded voice.
☐ 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.
Enrollee name
Agent name/ID number

Agent name/ID number . H2226_ERF_2024_C UHCSCO_ERF_H2226_2024

☐ Joining this plan could affect my employer of		•	
from an employer or union, joining this plan		•	
or my dependents could lose our other health or drug coverage completely and not get it back if I join this plan. I will talk to my employer or union. I will ask how joining this plan could affect			
my current plan. I may also want to check my employer or union's website, or read any			
information sent to me. If there is no informa	·	•	
administrator or the office that answers que		•	
Estate Recovery Awareness: MassHealth i the estates of certain MassHealth members	*		
age and are receiving long-term care in a nu	• •	•	
information about MassHealth estate recove	•		
$\hfill \square$ My response to this form is voluntary. Howe	ver, failure to respond may a	affect enrollment in the	
plan.			
When I sign below, it means that I have read a	nd understand the informa	tion on this form	
If I sign as an authorized representative, it means		•	
show written proof (power of attorney, guardians			
understand that I will need to submit written pro- behalf of the member beyond this application. A			
received my UnitedHealthcare member ID card,			
UnitedHealthcare member ID card to update my		•	
Signature of applicant/member/authorized re	presentative Today's date	e	
If you are the authorized representative	e, please sign above ar	nd complete the	
information below			
*Not a Sales Agent			
Last name	First name		
Addison			
Address			
City	State	ZIP code	
Phone number () -	Relationship to applican	it	
Enrollee name			
Agent name/ID number			
H2226_ERF_2024_C		CSMA24HM0133956_000	

UHCSCO_ERF_H2226_2024

For Licensed Sales	Representative/age	ncy use only	1	
Licensed Sales Representative/writing ID		Initial receipt date		
Licensed Sales Representative/agent name		Proposed effective date		
Agent must complete				
☐ IEP (MA-PD enrollees)	☐ ICEP (MA enrollees)	☐ IEP (MA-PD enrollees eligible 2nd IEP)		☐ OEP (Jan 1 - Mar 31)
☐ OEP (Newly eligible) ☐ SEP (Chronic)	☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining)	☐ SEP (Change in residence) ☐ AEP (October 15-December 7)		☐ SEP (Loss of EGHP coverage) ☐ OEPI
☐ SEP (SEP reason)				
Licensed Sales Repre	sentative signature (opti	ional)	Da	te

Please mail or fax this completed form to:

UnitedHealthcare 950 Winter ST, STE 3800 Waltham, MA 02451

Fax: 1-855-250-2168

Fax the front and back of each page

Enrollee name
Agent name/ID number _
H2226 ERF 2024 C
UHCSCO ERF H2226 2024

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.

UHC Senior Care Options MA-Y001 (HMO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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 and does not have any other comprehensive health insurance, except 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 1-844-560-4944 TTY **711**, daily, 8:00 a.m. to 8:00 p.m. This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

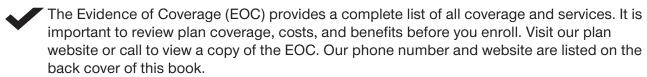
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

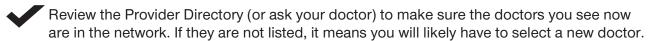
OMB No. 0938-1378 Expires: 7/31/2024 H2226_ERF_2024_C UHCSCO_ERF_H2226_2024

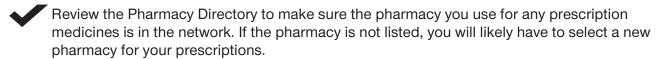
Enrollment checklist

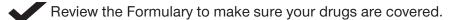
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

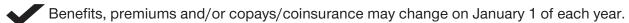


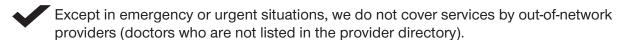


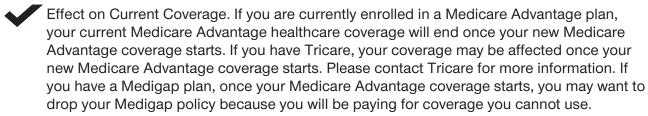




Understanding important rules







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.