





## 2025 MassHealth SCO Medicare Advantage Enrollment Request Form

☐ UHC Senior Care Options	MA-Y001 (HMO D-SNP) H2226-001-000	
☐ UHC Senior Care Options	NHC MA-Y002 (HMO D-SNP) H2226-003-00	)0

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	•			
MassHealth Number You must have MassHealth Standa			organization. To apply	
for MassHealth, call 1-888-834-372				
hearing loss).				
Information about you (Please	type or pri	nt in black or blue ink		
Last name	First name		Middle initial	
Birth date		Sex □ Male □ Female		
Home phone number ( )	_	Mobile phone number ( ) —		
□ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.				
Social Security number				
(Required for people who are enrolling in D-SNP plans):				
Name of skilled nursing facility (if applicable)				
Enrollee name				
Agent name/ID number				
H2226_ERF_2025_C UHCSCO_ERF_H2226_2025		U	HMA25HM0221003_000	

Medicare number					
Permanent residence streehomelessness, a PO Box	•				
City	cy County Sta			State	Zip code
Mailing address (Only if it	's different fro	om above. Yo	u can give	e a P.O. box	x.)
City				State	Zip code
Email address (optional)					
Do you have other insura (Examples: Other private in programs.) If yes, what is it?			-	_	☐ Yes ☐ No VA benefits or state
Name of other insurance					
Member number	Group n	Group number RxBin		xBin	RxPCN (optional)
Answering these question them out.	s is your choic	ce. You can't b	e denied	coverage be	cause you don't fill
A few questions to he	-	• • •			
1. Would you prefer plan	information i	n another lan	guage or	an accessib	le format?
If you would prefer plan you'd like: ☐ Spanish Other		•	•		•
If you don't see the lang 711, 8 a.m8 p.m. local	•	•			
2. Are you Hispanic, Latin  No, not of Hispanic Yes, Mexican, Mexican Yes, Puerto Rican Yes, Cuban Yes, another Hispanic	c, Latino/a, or iican America	Spanish origir n, or Chicano/	n a	at apply.	
Enrollee name					
Agent name/ID number					
H2226_ERF_2025_C JHCSCO_ERF_H2226_2025				UH	IMA25HM0221003_000

I choose not to answer	S
3. What's your race? Select all that apply.	
American Indian or Alaska Native	Black or African American
Asian:	Native Hawaiian or Pacific Islander:
Asian Indian	Guamanian or Chamorro
Chinese	Native Hawaiian
Filipino	Samoan
Japanese	Other Pacific Islander
Korean	
Vietnamese	White
Other Asian	I choose not to answer
Member/Citizen of a federal or state	recognized Tribe (name of Tribe)
4 What is your gander? Salest ans	
4. What is your gender? Select one.	Luga a different torra
Woman	I use a different term:
Man	Labarra makka amanan
Non-binary	I choose not to answer
5. Which of the following best represents	how you think of yourself? Select one.
Lesbian or gay	I use a different term:
Straight, that is, not gay or lesbian	
Bisexual	I choose not to answer
2.56/.dai	
6. Do you or your spouse work?	☐ Yes ☐ No
Do you or your spouse have other health ins	surance that will cover medical services?
(Examples: Other employer group coverage	, LTD coverage, Workers' Compensation,
auto liability, or Veterans benefits)	☐ Yes ☐ No
If yes, please complete the following:	
Name of health insurance company	
Member number	
7. Please give us the name of your primar	y care provider (PCP), clinic or health center.
You can find a list on the plan website or in	
Tod can find a not on the plan website of in	and I fortage Directory.
Enrollee name	
Agent name/ID number	
	LIHMA25HM0221003 000

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Provider or PCP full name	-
Provider/PCP number	(Please enter the number exactly as it appears or the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)
Are you now seeing or have you recently seen this	provider? ☐ Yes ☐ No
Please read and sign	
By completing this form, I agree to the following	g:
contract with the federal government. Unitedly Commonwealth of Massachusetts/MassHealth need to keep my MassHealth Standard plan.	are® SCO, is a Medicare Advantage plan and has a Healthcare® SCO also has a contract with the th. This is not a Medicare Supplement plan. I will I must keep both Hospital (Part A) and Medical eep paying my Part B premium if I have one, unless
period. I will no longer be covered by United Following the month I request to leave United a specific service area. If I move out of the are notify the plan so that I can disenroll and find	edHealthcare® SCO if I have a qualifying election Healthcare® SCO on the first day of the month Healthcare® SCO. UnitedHealthcare® SCO serves ea that UnitedHealthcare® SCO serves, I need to a new plan in my new area. Once I am a member appeal plan decisions about payment or services
the country, except for limited coverage near urgent care outside of the U.S. See the Sumn	enerally not covered under Medicare while out of the U.S. border. This plan covers emergency and nary of Benefits for more information. coverage begins, I must get all of my medical and
prescription drug benefits from UnitedHealthough	care. Benefits and services authorized by IHealthcare "Evidence of Coverage" document ber agreement) will be covered. Neither Medicare
☐ I understand that I can be enrolled in only one	e Medicare Advantage (MA) plan at a time - and end my enrollment in another MA plan (exceptions
Release of information: By joining this Medic will share my information with Medicare, who	Federal law that authorize the collection of this
	ny protected health information with organizations applicable law as required to administer my health
Enrollee name	

<ul> <li>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.</li> <li>Joining this plan could affect my employer or union health benefits. If I have health coverage from an employer or union, joining this plan may change how my current coverage works. Me 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 information on whom to contact, my benefits administrator or the office that answers questions about my coverage can help.</li> <li>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</li> <li>My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.</li> </ul>					
When I sign below, it means that I have rea	nd and understand th	e 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 representation below (*Not a Sales Agen	-	bove and complete the			
Last name	First name				
Address					
City	State	Zip code			
Phone number ( ) — Relationship to applicant					
Enrollee nameAgent name/ID numberH2226_ERF_2025_C UHCSCO_ERF_H2226_2025		UHMA25HM0221003_000			

For individuals help	ping enrollee with	CO	mplet	ting this form o	nly
Complete this section i	f you're an individual	(i.e.	agents	s, brokers, SHIP co	ounselors, family
members, or other third	d parties) helping an e	enrol	llee fill	out this form.	
Name		Rel	lations	hip to enrollee	
Signature			tional I	Producer Number	(Agents/Brokers only)
For Licensed Sales	Representative/a	age	ncy u	se only	
Licensed Sales representative/Writing ID				Initial receipt dat	e
Licensed Sales represe	entative/agent name		Proposed effective date		
Agent must complete					
☐ IEP (MA-PD	☐ ICEP (MA enrollee	es)		P (MA-PD	□ OEP (Jan 1 -
enrollees)		•	enrol	lees eligible for	Mar 31)
			2nd I	EP)	
☐ OEP (Newly	☐ SEP (Dual LIS			P (Change in	☐ SEP (Loss of
eligible)	change of status)		resid	ence)	EGHP coverage)
Enrollee name					
Agent name/ID number					

☐ SEP (Chronic)	☐ SEP (Dual LIS maintaining)	☐ AEP (October 15- December 7)	□ OEPI		
☐ SEP (SEP reason) _	-				
Licensed Sales representative signature (optional)  Date					
Please mail or fax this completed form to:  UnitedHealthcare					
1325 Boylston Street, 11th Floor					
Boston, MA 02215					
	Fax: 1-855-250-2168				
	Fax the front and b	back of each page			

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 Senior Care Options 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 Senior Care Options 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.

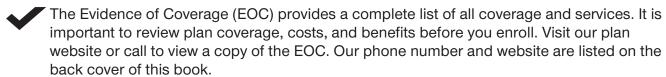
OMB No. 0938-1378 Expires: 6/30/2026 H2226\_ERF\_2025\_C UHCSCO\_ERF\_H2226\_2025

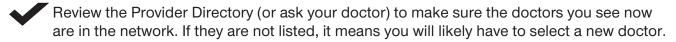
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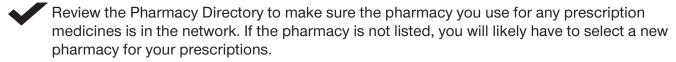
## **Enrollment checklist**

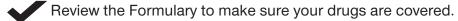
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits

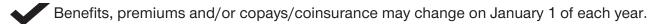


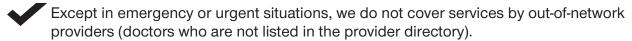


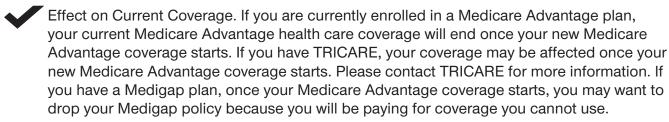




## **Understanding important rules**







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.