UHC Dual Complete MN-Y001 (HMO D-SNP) Enrollment Form

UHC Dual Complete MN-Y001 (HMO D-SNP) Enrollment Telephone Numbers

844-560-4944, TTY for the hearing impaired at 711.
8 a.m.–8 p.m. local time, 7 days a week. The call is free.

UHC Dual Complete MN-Y001 (HMO D-SNP) Member Services Telephone Numbers

844-368-5888. TTY for the hearing impaired at 711.
8 a.m.–8 p.m.: October–March, seven days a week;
April–September, Monday through Friday. The call is free.

Return the completed form to: UHC Dual Complete MN-Y001 (HMO D-SNP)

P.O. Box 30769
Salt Lake City, UT 84130-0769
Fax the front and back of each page to: 888-950-1169

Please contact UHC Dual Complete MN-Y001 (HMO D-SNP) at the number listed above if you need information in another language or format.

UHC Dual Complete MN-Y001 (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UHC Dual Complete MN-Y001 (HMO D-SNP) depends on contract renewal.

Member name MHCP member number

UHC Dual Complete MN-Y001 (HMO D-SNP) Enrollment Request Form

To join UHC Dual Complete MN-Y001 (HMO D-SNP), you must have **Medicare Part A, Medicare Part B, and Medical Assistance (Medicaid) without a medical spenddown**, and be at least 18 and under age 65, have a certified disability through the Social Security Administration or the State Medical Review Team, and live in the UHC Dual Complete MN-Y001 (HMO D-SNP) service area.

Section 1. Tell us about yourself

1	Name: (first, Optional: middle, last)			
2	Date of birth (__ __ /__ __ /__ __ __ __) M M D D Y Y Y Y		Sex: ☐ Male ☐ Female	
3	Phone number ( ) –		Another phone number (Optional): ( ) –	
4	Address where you live (P.O. Box is not allowed)			
	City	State	ZIP code	County
5	Address where you get mail (if different from where you live)			
	City	State	ZIP code	County
6	Do you live in a long-term care facility? ☐ Yes ☐ No If "Yes", fill in the information below: Name of the facility:		Phone number: ( ) –	
7	Do you need an interpreter? ☐ Yes ☐ No If "Yes," check the language below: ☐ 01 Spanish ☐ 05 Lao ☐ 09 Amharic ☐ 16 French ☐ 02 Hmong ☐ 06 Russian ☐ 10 Arabic ☐ 20 Korean ☐ 03 Vietnamese ☐ 07 Somali ☐ 12 Oromo ☐ 21 Karen ☐ 04 Khmer (Cambodian) ☐ 08 ASL (American Sign Language) ☐ 14 Burmese ☐ 98 Other _____ ☐ 15 Cantonese			
8	Authorized Representative		Authorized Representative phone number ( ) –	

Member name _____ MHCP member number _____

Section 2. Tell us about yourself

Please tell us a little more about yourself. **You are not required to answer questions or give any information in this section. It's your choice to share this information with us.** We can't deny you coverage if you don't answer them.

8 Do you want us to send you information in a language other than English? ☐ Yes ☐ No

If "Yes," write language: _____

9 Do you want us to send you information in an accessible format? ☐ Yes ☐ No

If "Yes," check format: ☐ Braille ☐ Large print ☐ Audio

Please contact UHC Dual Complete MN-Y001 (HMO D-SNP) at 844-368-5888 if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m.–8 p.m.: October–March, seven days a week; April–September: Monday through Friday. TTY users can call 711.

10 Are you Hispanic, Latinola, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, another Hispanic, Latino/a or Spanish origin
- ☐ I choose not to answer
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban

11 What's your race? Select all that apply.

- ☐ American Indian or Alaskan Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ I chose not to answer
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan

12 Do you want to get information by email? ☐ Yes ☐ No

If "Yes," provide your email address.

Email: _____

13	Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No ☐ Does not apply
14	Name the primary care clinic/care system you are choosing:	Primary care clinic/care system provider ID number found in the Provider and Pharmacy Directory:

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Section 3. Tell us about your Medicare and Medical Assistance (Medicaid) coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) ID Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

15	Medicare number:	MHCP member number:

Section 4. Tell us about your health coverage including your prescription drug coverage:

Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

16	Do you have other health coverage? ☐ Yes ☐ No If "Yes," fill in the information below:	
17	Name of your plan (and employer, if applicable):	Group number: ID number:

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join UHC Dual Complete MN-Y001 (HMO D-SNP). Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Section 5. Tell us about your enrollment eligibility

Please read the following statements carefully and check the box if the statement applies to you. **Check all that apply.** By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

☐ I am new to Medicare.

☐ I have both Medicare and Medical Assistance (Medicaid) (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I recently had a change in my Medical Assistance (Medicaid) (newly got Medicaid or had a change in level of Medicaid assistance) on (date) _____ .

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) _____ .

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☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____ .

☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (date) _____ .

☐ I am leaving employer or union coverage on (date) _____ .

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____ .

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) _____ .

☐ I recently was released from incarceration. I was released on (date) _____ .

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____ .

☐ I recently obtained lawful presence status in the United States. I got this status on (date) _____ .

☐ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact UHC Dual Complete MN-Y001 (HMO D-SNP) at 844-560-4944 (TTY users should call 711) to find out if you're eligible to enroll. We are open 8 a.m.–8 p.m. local time, 7 days a week.

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Please read the information on page 7 and sign below.

When you sign this form, it means that you understand the information you read.

Name of applicant (Please print)

Signature Today's date

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

Name (Print) Relationship to enrollee

Address (Print) Telephone number

When the form is complete, mail or fax it to UHC Dual Complete MN-Y001 (HMO D-SNP). Our address and fax number are on the cover of this form.

Office use only:

Date: _____

Name of Authorized Sales Person: _____

Licensed Sales Agent ID: _____

Effective Date of Enrollment _____

Election Code _____

LIS Copay Level _____

LIS Copay Effective Date _____

Approved by _____

Member name MHCP member number

Information and acknowledgment statements

- My response to this form is voluntary. I understand that my enrollment in UHC Dual Complete MN-Y001 (HMO D-SNP) may be affected if I don't respond.
- I must keep Medicare Part A and Part B and Medical Assistance (Medicaid) to stay in UHC Dual Complete MN-Y001 (HMO D-SNP).
- By joining UHC Dual Complete MN-Y001 (HMO D-SNP), 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 collection of this information (see Privacy Act Statement below).
- On the date UHC Dual Complete MN-Y001 (HMO D-SNP) coverage begins, I must get my medical and prescription drug benefits from UHC Dual Complete MN-Y001 (HMO D-SNP).
- Benefits and services UHC Dual Complete MN-Y001 (HMO D-SNP) provides and contained in my Evidence of Coverage are covered. Neither Medicare nor UHC Dual Complete MN-Y001 (HMO D-SNP) will pay for benefits or services that are not covered.
- I understand that UHC Dual Complete MN-Y001 (HMO D-SNP) doesn't usually cover people while they're out of the country except under limited circumstances.
- If I move, I need to tell my County Worker.
- I can choose to leave UHC Dual Complete MN-Y001 (HMO D-SNP) at certain times of the year. I understand that I will be enrolled in UHC Dual Complete MN-Y001 (HMO D-SNP) through the last day of the month. I understand that I will be automatically enrolled in Medical Assistance fee-for-service unless I am otherwise required to enroll in Families and Children.
- If I get a medical spenddown while enrolled in UHC Dual Complete MN-Y001 (HMO D-SNP) and do not pay it to the State, I will be disenrolled from UHC Dual Complete MN-Y001 (HMO D-SNP).
- The information on this enrollment form is correct to the best of my knowledge. I understand that I will be disenrolled from UHC Dual Complete MN-Y001 (HMO D-SNP) if I intentionally give false information on this form.
- My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance (Medicaid).

Member name MHCP member number

Privacy act statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

United Healthcare Dual Complete

CB5 (MCOs) (10-2021)

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Minnesota does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
Toll Free: **1-844-368-5888**, TTY **711**
Email: **UHC_Civil_Rights@uhc.com**

Auxiliary Aids and Services: UnitedHealthcare Community Plan of Minnesota provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact Member Services at 1-844-368-5888.**

Language Assistance Services: UnitedHealthcare Community Plan of Minnesota provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact Member Services at 1-844-368-5888.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: **ocrmail@hhs.gov**

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104

Voice: 651-539-1100
Toll free: 800-657-3704
MN Relay: 711 or 800-627-3529
Fax: 651-296-9042
Email: **Info.MDHR@state.mn.us**

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Voice: 651-431-3040 or use your preferred relay service

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-844-368-5888, TTY **711**

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအား အခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။*

កំណត់សម្គាល់៖ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះ ដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီနၤလၢ တၢ်ကကွဲးကျိုးထံဝဲဒဉ် လံာ်တီလံာ်မိတခါအံၤအဃိ ကိးလိတဲစိနိဉ်ဂ်ၢ် လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Member name MHCP member number

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 first page of this form.

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.

Additional requirements are as follows:

- ✔ You live in our service area; and
- ✔ You have both Medicare Part A and Medicare Part B; and
- ✔ You are a United States citizen or are lawfully present in the United States; and
- ✔ You are age 18–64; and
- ✔ You have a certified disability through the Social Security Administration or the State Medical Review Team.

Understanding the benefits

- ✔ The Member Handbook provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to get a copy of the Member Handbook.
- ✔ Review the Provider and Pharmacy 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 Provider and Pharmacy 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.
- ✔ Review the Formulary (List of Covered Drugs) to make sure your drugs are covered.

Understanding important rules

- ✔ Benefits may change on January 1 of each year.
- ✔ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy directory).