OMB No. 0938-1378 Expires: 7/31/2023

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in Commonwealth Care Alliance SCO Program

2022 MassHealth Senior Care Options (SCO) & Medicare Advantage Enrollment Form

MassHealth Information

▶ **Are you enrolled in MassHealth?** ◯ Yes ◯ No

Please write in your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name.

MassHealth ID number:

Name of primary care doctor you have selected:

You must be 65 years or older, have MassHealth Standard benefits, live in the plan's service area, not be a resident of a chronic hospital, and not have any other comprehensive health insurance to enroll in a senior care organization. To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you require assistance, please contact CCA at 888-537-5816 (TTY: 711)
7 days a week, 8 a.m.–8 p.m. (From April 1–September 30: Monday through Friday, 9 a.m.–6 p.m.)

Member Information

Last name:

First name:

Middle initial: (optional)

Title: (optional)
◯ Mr. ◯ Mrs. ◯ Ms.

Gender:
◯ M ◯ F

Birth date: (mm/dd/yyyy)

Preferred format for materials:
◯ Braille ◯ Large print ◯ Audio cassette ◯ Other

Preferred written language:

Preferred spoken language:

Permanent address (where you live)

Street address:

City:

State:

Zip code:

Phone number:

Mailing address (where you get mail, if different from where you live)

Street address:

City:

State:

Zip code:

Phone number:

If you are a resident of a nursing facility, enter the name and address here.

Name of nursing facility:

Street address:

City:

State:

Zip code:

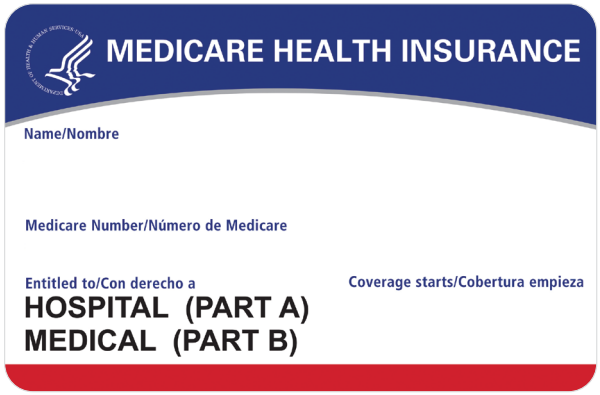
Phone number:

Medicare Information

- Please take out your 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 the Social Security Administration or Railroad Retirement Board.



You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name:

Medicare number:

Entitled to:

HOSPITAL (Part A)

Coverage starts: (mm/dd/yyyy; optional)

MEDICAL (Part B)

Coverage starts: (mm/dd/yyyy; optional)

Other Health Insurance

▶ **Do you have any health insurance other than Medicare and MassHealth?** ◯ Yes ◯ No

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

Your Medical Care

By completing this enrollment application, I agree to the following:

Commonwealth Care Alliance SCO Program is a Medicare Advantage plan and has a contract with the federal government. Commonwealth Care Alliance SCO Program also has a contract with the Commonwealth of Massachusetts/MassHealth. I will need to keep my MassHealth Standard and my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Because I have MassHealth, I may leave Commonwealth Care Alliance SCO Program at any time. I will no longer be covered by Commonwealth Care Alliance SCO Program on the first day of the month following the month I request to leave Commonwealth Care Alliance SCO Program. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

Commonwealth Care Alliance SCO Program serves a specific service area. If I move out of the area that Commonwealth Care Alliance SCO Program 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 Commonwealth Care Alliance SCO Program, I have the right to appeal plan decisions about payment or services if I disagree with them. I will read the Evidence of Coverage from Commonwealth Care Alliance SCO Program when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date that Commonwealth Care Alliance SCO Program coverage begins, I must get all my health care from Commonwealth Care Alliance SCO Program with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Commonwealth Care Alliance SCO Program and other services contained in my Commonwealth Care Alliance SCO Program Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR COMMONWEALTH CARE ALLIANCE SCO PROGRAM WILL PAY FOR THE SERVICES.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Commonwealth Care Alliance SCO Program, he or she may be compensated based on my enrollment in Commonwealth Care Alliance SCO Program.

Release of Information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Commonwealth Care Alliance SCO Program will release my information to Medicare, who may release it for research and other purposes that 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 authorized to act on behalf of the individual under the laws of the state where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual

(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 Commonwealth Care Alliance SCO Program or by Medicare.

One of our Enrollee Service Representatives will be calling you within the next 10 days to verify the information on this form and to make sure you understand our plan rules.

Please provide a telephone number we may use for that call:

Best time to call:

◯ morning ◯ afternoon ◯ evening

Signature

Signature:

Print name:

Today's date: (mm/dd/yyyy)

If you have chosen an authorized representative, the authorized representative must sign above and provide the following information.

Name:

Phone number:

Address:

Relationship to enrollee:

OFFICE USE ONLY

Name of staff member/agent/broker, if assisted in enrollment:

Plan ID No.:

Agent NPN:

Effective date of coverage: (mm/dd/yyyy)

Enrollment period:

◯ ICEP/IEP ◯ AEP ◯ OEP

◯ SEP (type:) _____ ◯ Not eligible