CCA One Care 2027

Enrollment Form

OMB No. 0938-1378 Expires: 2/28/2029

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Commonwealth Care Alliance®
P.O. Box 8738
Dayton, OH 45401-8738

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call CCA One Care (HMO D-SNP) at 855-210-1659. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a CCA One Care (HMO D-SNP) al 855-210-1659 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

CCA One Care (HMO D-SNP) is a Dual Special Needs Plan (D-SNP) that contracts with both Medicare and MassHealth (Medicaid) to provide benefits of both programs to enrollees. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone age 21 - 64 who qualifies for MassHealth Standard or CommonHealth and Original Medicare and does not have any other comprehensive health insurance, except Medicare.

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Section 1 – All fields on this page are required (unless marked optional)		
Select the plan you want to join: ☐ CCA One Care (HMO D-SNP)		
FIRST name:	LAST name:	Middle initial:
Birth date: (MM/DD/YYYY) (__ __/__ __/__ __ __ __)	Sex: ☐ Male ☐ Female	Phone number: ( ) Cell number: ( )
Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):		
City:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street address:		
City:	State:	ZIP Code:
Your Medicare Information:		
Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __		
Your MassHealth (Medicaid) Information:		
MassHealth Number: _____		
Answer these important questions:		
Will you have other prescription drug coverage (like VA, TRICARE) in addition to CCA One Care? ☐ Yes ☐ No		
Name of other coverage: _____	Member number for this coverage: _____	Group number for this coverage: _____
Dual Eligible Special Needs (D-SNP) plans are for those who qualify for Medicare and Medicaid. By enrolling in this plan, you understand that you must remain enrolled in your state Medicaid program to remain eligible for this plan,		
1) Are you enrolled in your state Medicaid program? ☐ Yes ☐ No		
2) If "yes", provide your Medicaid ID number: _____		

IMPORTANT: Read and sign below:	
By completing this enrollment application, I agree to the following: I must keep both Hospital (Part A) and Medical (Part B) to stay in CCA One Care.	
By joining this Medicare Advantage Plan, I acknowledge that CCA One Care 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). Your response in this form is voluntary. However, failure to respond may affect enrollment in the plan.	
I understand that I can be enrolled in only one MA or Part D plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).	
I understand that when my CCA One Care coverage begins, I must get all of my medical and prescription drug benefits from CCA One Care. Benefits and services provided by CCA One Care and contained in my CCA One Care "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CCA One Care will pay for benefits or services that are not covered.	
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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (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 Medicare.	
Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

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

Select one if you want us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact CCA One Care at 866-610-2273 if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday, 8 a.m. to 8 p.m. Eastern Time (ET), and from October 1 to March 31, the same hours, seven days a week. TTY users can call 711.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via e-mail. Select one or more.

☐ 2027 CCA One Care (HMO D-SNP) Pre-Enrollment Kit

Email address:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):

Agent/Broker use only. Agent/Broker must complete.

Initial receipt date:	Proposed effective date:

☐ SEP (Once per month integrated care SEP for dually eligible individuals)	☐ OEPI (Live in an LTC facility)
☐ IEP (New to Medicare)	☐ OEPI (Moving out of an LTC facility)
☐ IEP2 (Had Medicare prior, but now turning 65)	☐ SEP (Recent change in Medicaid)
☐ ICEP (Had Part A and recently signed up for Part B)	☐ SEP (Recent change in Extra Help paying for prescriptions)
☐ AEP (Annual Election Period)	☐ SEP (Left employer coverage)
☐ OEP (In a Med Adv Plan and want to change; Jan 1 – Mar 31)	☐ SEP (Other _____)
☐ OEP (In a Med Adv Plan 3 mos. And want to change; Apr 1 – Dec 31	

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT: Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.