commonwealth care alliance® MASSACHUSETTS

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ENROLLMENT FORM 2024

Who can use this form?

People with MassHealth Standard over 65, with or without Medicare (if applicable)

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 January1)
- 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 MassHealth Number and your Medicare Number (the number on your red, white, and blue Medicare card) if applicable
- 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.
- $0 premium

What happens next?

Send your completed and signed form to:

Commonwealth Care Alliance
30 Winter Street
Boston, MA 02108

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

How do I get help with this form?

Call CCA at 855-210-1790. 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 al 855-210-1790 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 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.

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commonwealth care alliance MASSACHUSETTS

MassHealth

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

Section 1: All fields in this section are required (unless marked optional)

☐ **CCA Senior Care Options (HMO D-SNP) $0 per month**

☐ **CCA Senior Care Options (MassHealth only) $0 per month**

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in CCA Health 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 your name.

MassHealth Number

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 am – 8 pm (From April 1 – September 30: Monday through Friday, 8 am – 8 pm)

Information about you (please type or print in black or blue ink)

Last Name	First Name	Middle Initial

Birth Date	Sex: ☐ Male ☐ Female

Home Phone Number ( ) -	Mobile Phone Number ( ) -

Name of Skilled Nursing Facility (if applicable)	Medicare Number (if applicable)

Permanent Street Address **(not a P.O. Box)**

City	Country	State	Zip Code

Enrollee's Name _____

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	State	Zip Code

Email Address (optional)

Will you have other prescription drug coverage in addition to CCA Senior Care Options and MassHealth (Medicaid)? ☐ **Yes** ☐ **No**

(Examples: other private insurance, TRICARE, Federal employee heath benefits coverage, VA Benefits, or State programs.)

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

Name of Other Insurance

Member Number	Group Number
Rx Bin	Rx PCN (optional)

Please read and sign below

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

Commonwealth Care Alliance Senior Care Options (HMO D-SNP) 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.

Enrollee's Name _____

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.

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.

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.

Signature of applicant/member/authorized representative	**Today's Date**

If you are the authorized representative, you must sign above and provide the following information:
***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Home Phone Number ( ) -	Relationship to Applicant	

Section 2

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

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

What's your race? Select all that apply.

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

Enrollee's Name _____

A few questions to help us manage your plan

Would you prefer plan information in another language or an accessible format? ☐ **Yes** ☐ **No**

What language do you prefer your plan information: ☐ English ☐ Spanish

What accessible format: ☐ Braille ☐ Large Print ☐ Other_____

You can get this document for free in other formats, such as large print, braille, or audio. Call 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.) The call is free.

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

Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ **Yes** ☐ **No**

If "**yes**," please complete the following:

Name of Health Insurance Company

Member Number

Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the provider directory.

Provider or PCP full name

Enrollee's Name _____

For sales representative/agency use only	
Licensed Sales Representative/NPN	Initial Receipt Date
Licensed Sales Representative/Agent Name	Proposed Effective Date
Agent must complete ☐ IEP (MA-PD Enrollee) ☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ OEP (newly eligible) ☐ SEP (Change in residence) ☐ SEP (Chronic) ☐ AEP (October 15 – December 7) ☐ SEP (SEP Reason)	☐ ICEP (MA Enrollees) ☐ OEP (Jan 1 – Mar 31) ☐ SEP (Dual LIS change of status) ☐ SEP (Loss of EGHP coverage) ☐ SEP (Dual LIS maintaining) ☐ OEPI

Licensed Sales Representative Signature **Date**

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Please mail or fax completed form to:
ATTN: Enrollment Department
30 Winter Street
Boston, MA 02108

Enrollee's Name _____

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.