



Senior Care Options
Medicare Advantage

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in [[plan name longer name name]].

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

You must have MassHealth Standard benefits to enroll in a senior care organization. To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss.)

Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure. Yes No
Generally, if you answered yes to this question, you cannot enroll in SCO.

However, if you answered yes to this question and you do not need regular dialysis anymore or have had a successful kidney transplant, please attach a note from your doctor indicating that either you no longer need dialysis or have had a successful kidney transplant.

Name of primary care doctor you have selected

Member information

Last Name	First Name	MI	Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Format for materials <input type="checkbox"/> Braille <input type="checkbox"/> Audio cassette <input type="checkbox"/> Large Print	
Written Language Preferred		Spoken Language Preferred	

Permanent Address (where you live)

Street Address		City/Town
State	Zip Code	Telephone Number

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

Street Address		City/Town
State	Zip Code	Telephone Number

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

Name _____


Street Address		City/Town
State	Zip Code	Telephone Number

Medicare Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue 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.

MEDICARE				HEALTH INSURANCE	
SAMPLE ONLY					
Name: _____					
Medicare Claim Number			Sex ____		
_____ - _____ - _____					
Is Entitled To			Effective Date		
HOSPITAL (Part A)			_____		
MEDICAL (Part B)			_____		

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:

This senior care organization [[plan name longer name name]] is a Medicare Advantage plan and has a contract with the federal government. [[plan name longer name name]] 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 [[plan name longer name name]] at any time. I will no longer be covered by [[plan name longer name name]] on the first day of the month following the month I request to leave [[plan name longer name name]]. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

[[plan name longer name name]] serves a specific service area. If I move out of the area that [[plan name longer name name]] 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 [[plan name longer name name]], 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 [[plan name longer name name]] 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 [[plan name longer name name]] coverage begins, I must get all my health care from [[plan name longer name name]] with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by [[plan name longer name name]] and other services contained in my [[plan name longer name name]] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR [[plan name longer name name]] 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 [[plan name longer name name]], he or she may be compensated based on my enrollment in [[plan name longer name name]].

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 this senior care organization ([[plan name longer name name]]) 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 [[plan name longer name name]] 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; or _____ evening.

Signature

Signature: _____ Today's Date: _____

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

Name: _____

Address: _____

Phone Number: _____

Relationship to Enrollee: _____

Office Use Only

Name of staff member/agent/broker *(if assisted in enrollment)*: _____

Plan ID No.: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____

SEP (type): _____ Not Eligible: _____

NOTES