This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in Tufts Health Plan Senior Care Options.

TUFTS Health Plan
a Point32Health company

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

☐ Tufts Health Plan Senior Care Options (HMO SNP) H8330-001-000
☐ Tufts Health Plan Senior Care Options CW (HMO SNP) H8330-002-000
☐ Tufts Health Plan Senior Care Options MassHealth Standard (Medicaid) Only*

*If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our Tufts Health Plan Senior Care Options program.

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 be 65 years or older, have MassHealth Standard benefits, live in the Tufts Health Plan Senior Care Options service area, not be a resident of a chronic hospital, and not have any other comprehensive health insurance except Medicare, 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).

►Name of primary care doctor you have selected: _____ Are you a current patient? Yes ☐ No ☐

Member Information

Last name	First name	MI	Mr.☐ Mrs.☐ Ms.☐
Date of birth	Sex M☐ F☐	Preferred format for materials ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD Other_____	
Written language preferred		Spoken language preferred	

Permanent address (where you live)

Street address		City/town
State	Zip	Telephone number

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

Street address		City/town
State	Zip	Telephone number

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

Name of nursing facility		
Street address		City/town
State	Zip	Telephone number

Please go to the next page. ►

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

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

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

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ I choose not to answer

Medicare Information

►Please take out your Medicare card to complete this section.

- Please type your Medicare number, indicate your gender, and type the effective dates in the card shown to the right, so it matches 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.

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

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:

Tufts Health Plan Senior Care Options is a Medicare Advantage plan and has a contract with the federal government. Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options at any time. I will no longer be covered by Tufts Health Plan Senior Care Options on the first day of the month following the month I request to leave Tufts Health Plan Senior Care Options. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

Tufts Health Plan Senior Care Options serves a specific service area. If I move out of that area that Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options, 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 Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options coverage begins, I must get all my health care from Tufts Health Plan Senior Care Options with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Tufts Health Plan Senior Care Options and other services contained in my Tufts Health Plan Senior Care Options Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TUFTS HEALTH PLAN SENIOR CARE OPTIONS WILL PAY FOR THE SERVICES.

Please go to the next page.►

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Tufts Health Plan Senior Care Options, he or she may be compensated based on my enrollment in Tufts Health Plan Senior Care Options.

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 Tufts Health Plan Senior Care Options 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 that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Tufts Health Plan Senior Care Options 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:_____

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):*

_____

Agent NPN: _____

Agency/FMO Name: _____

Plan ID No.: _____

Date Application Received: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ **OEP:** _____ **AEP:** _____

SEP (type): _____ **Not Eligible:** _____

Notes