TUFTS Health Plan

MassHealth

2027 MassHealth One Care & Medicare Advantage Enrollment Form

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in Tufts Health One Care. You must have both Medicare Part A and Part B and be eligible for Part D, be eligible for MassHealth Standard or MassHealth CommonHealth, live in the Tufts Health One Care service area, not have any other comprehensive health insurance except Medicare, and are not enrolled in a MassHealth Home and Community-based Services (HCBS) waiver, to enroll in a One 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).

◯ Tufts Health One Care (D-SNP) H5314-001-000

◯ Tufts Health One Care CW (D-SNP) H5314-002-000

MASSHEALTH INFORMATION

Are you enrolled in MassHealth?

◯ Yes ◯ No

MassHealth ID number:

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

Name of primary care doctor you have selected:

Are you a current patient?

◯ Yes ◯ No

MEMBER INFORMATION

First name: MI: Last name:

Title: ◯ 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:

Email address:

☐ I would like to sign up for eDelivery and get my Annual Notice of Change (ANOC), Member Handbook, Formulary, Provider and Pharmacy Directory electronically instead of by mail.

☐ I would like to get my medical Explanation of Benefits (EOB) electronically instead of by mail.

Permanent address (P.O. Box not allowed unless you do not have a permanent residence)

Street address:

City:

State:

Zip:

Telephone number:

☐ This is a mobile number (optional)

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

Street address:

City:

State:

Zip:

Telephone number:

☐ This is a mobile number (optional)

By providing an SMS-enabled phone number you are giving Tufts Health One Care permission to send you text messages about your plan and benefits. You may unsubscribe from text messages at any time. For texting terms of use, please visit https://tuftshealthplan.com/text-terms-of-use.

☐ Opt out of SMS text messages

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

Name of nursing facility:

Street address:

City:

State:

Zip:

Telephone number:

MEDICARE INFORMATION

Please take out your red, white and blue 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: (as it appears on your Medicare card; optional)

Medicare number:

Is entitled to:

Effective date: (optional; mm/dd/yyyy)

HOSPITAL (Part A)

MEDICAL (Part B)

Please go to the next page. ›

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

Tufts Health One Care serves a specific service area. If I move out of the area that Tufts Health One Care 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 One Care, I have the right to appeal plan decisions about payment or services if I disagree with them. I will read the Member Handbook from Tufts Health One Care 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 One Care coverage begins, I must get all my health care from Tufts Health One Care with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Tufts Health One Care and other services contained in my Tufts Health One Care Member Handbook document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TUFTS HEALTH ONE CARE 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 Tufts Health One Care, he or she may be compensated based on my enrollment in Tufts Health One Care.

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 One Care 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 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 One Care 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:

Send your completed and signed form to:

Tufts Health One Care Mail Stop B3
Point32Health
1 Wellness Way
Canton, MA 02021-9936

Fax: (617)-673-0785

OFFICE/BROKER USE ONLY

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

Agent NPN (brokers only): Agency name: FMO name:

Date application received: Effective date of coverage:

Enrollment period:

☐ ICEP/IEP ☐ AEP ☐ OEP ☐ Integrated Care SEP (P) ☐ Other SEP:

NOTES

TUFTS Health Plan

a Point32Health company

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-393-3154 (TTY: 711), seven days a week from 8 a.m. to 8 p.m., or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-393-3154 (TTY: 711), los siete días a la semana, de 8 a.m. a 8 p.m., o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-393-3154（文本电话：711, 每天早上 8 点到晚上 8 点, 或咨询您的服务提供商。

Français (French) ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-393-3154 (TTY: 711), sept jours sur sept, de 8 a.m. à 8 p.m., ou parlez à votre fournisseur.

Việt (Vietnamese) LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-393-3154 (Người khuyết tật: 711), bảy ngày trong tuần từ 8:00 sáng đến 8:00 tối, hoặc trao đổi với người cung cấp dịch vụ của bạn.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-393-3154 (TTY: 711), Sieben Tage die Woche von 8 bis 20 Uhr., an oder sprechen Sie mit Ihrem Provider.

Japanese 注：他の言語をお話しになる場合、無料の言語支援サービスをご利用いただけます。また、適切な補助サポートおよびサービスをアクセス可能な形式の情報として無料でお届けしております。1-855-393-3154（TTY：711）（年中無休、午前 8 時～午後 8 時）にお電話いただくか、ご利用のプロバイダにお知らせください。

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-393-3154 (TTY: 711), 주 7 일 오전 8 시부터 오후 8 시까지, 번으로 전화하거나 서비스 제공업체에 문의하십시오.

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону
1-855-393-3154 (TTY: 711), семь дней в неделю с 8 a.m. до 8 p.m., или обратитесь к своему поставщику услуг.

(Arabic) تنبيه: إذا كنت تتحدث لغة أخرى، فستكون هناك خدمات مساعدة لغوية مجانية متاحة لك. كما تتوفر أيضًا مساعدات وخدمات مساعدة مناسبة لتقديم المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل على الرقم 1-855-393-3154 (رقم الهاتف النصي: 711)، على مدار الأسبوع من الساعة 8 صباحًا حتى الساعة 8 مساءً، أو تحدث إلى موفر الخدمة الذي تتعامل معه.

हिंदी (Hindi)न दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-393-3154 (TTY: 711) ,सप्ताह के सातों दिन, सुबह 8 बजे से रात 8 बजे तक।, पर कॉल करें या अपने प्रदाता से बात करें।

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-855-393-3154 (tty: 711), sette giorni su sette dalle 8.00 alle 20.00., o parla con il tuo fornitore.

Português (Portuguese) ATENÇÃO: Se fala Português, estão disponíveis para si serviços gratuitos de assistência linguística. Estão também disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-393-3154 (TTY - Dispositivo das telecomunicações para surdos: 711), sete dias por semana, das 8h às 20h., ou fale com o seu prestador.

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-393-3154 (TTY: 711), siedem dni w tygodniu, od 8:00 do 20:00., lub porozmawiaj ze swoim dostawcą.

ភាសាខ្មែរ (Cambodian) ចូរចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងទៀត
សេវាជំនួយខាងភាសាដោយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សេវា
និងជំនួយសមស្របក្នុងការផ្តល់ព័ត៌មានជាទម្រង់ដែលអាចប្រើប្រាស់បានក៏មានដោយមិនគិតថ្លៃដងដែរ។
សូមទូរសព្ទទៅលេខ 1-855-393-3154 (TTY: 711), បានប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ពីម៉ោង 8 ព្រឹកដល់ម៉ោង 8
យប់ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ពីម៉ោង 8 ព្រឹកដល់ម៉ោង 8 យប់ ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-855-393-3154 (TTY: 711) oswa pale avèk founisè w la.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-855-393-3154 (TTY: 711), Επτά ημέρες την εβδομάδα, από τις 8:00 π.μ. έως τις 8:00 μ.μ., ή απευθυνθείτε στον πάροχό σας.

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑકિઝલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-393-3154 (TTY: 711), સપ્તાહના સાતેય દિવસ સવારે 8 વાગ્યાથી રાત્રિના 8 વાગ્યા સુધી., પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Tagalog PAUNAWA: Kung ikaw ay nagsasalita ng ibang lenggwahe, ang libreng tulong sa wika ay maari mong magamit. Ang naaangkop na mga pantulong at serbisyo upang magbigay ng impormasyon na naa-access na pormat ay makukuha rin nang walang bayad. Tumawag sa 1-855-393-3154 (TTY: 711), pitong araw sa isang linggo mula 8:00 ng umaga hanggang 8:00 ng gabi o maaring makipag usap sa provider.

ลาว(Laos) ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-855-393-3154 (TTY: 711), 7 ມື້ຕໍ່ອາທິດແຕ່ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ., ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.