





## 2025 MassHealth SCO Medicare Advantage Enrollment Request Form

| ☐ UHC Senior Care Options MA-Y001 (HMO D-SNP) H2226-001-000 |       |
|---|-------|
| ☐ UHC Senior Care Options NHC MA-Y002 (HMO D-SNP) H2226-003 | 3-000 |

This form is for people who have MassHealth Standard (Medicaid) benefits and choose to enroll in UnitedHealthcare® Senior Care Options. You must also have Medicare Parts A and B. 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 UnitedHealthcare® SCO program.

| MassHealth Standard (Medica                             | id) Informa    | ation                      |                              |  |
|---|----------------|----------------------------|------------------------------|--|
| Are you enrolled in MassHealth?                         | ] Yes □        | No                         |                              |  |
| Please write your MassHealth number                     | er or attach a | copy of your MassHealth    | card. Your MassHealth        |  |
| number is the 12-digit number under                     | your name.     |                            |                              |  |
| MassHealth Number                                       |                |                            |                              |  |
| You must have MassHealth Standa                         | rd benefits t  | o enroll in a senior care  | organization. To apply       |  |
| for MassHealth, call 1-888-834-372                      | 1 (TTY 1-80    | 0-497-4648 for people w    | rith partial or total        |  |
| hearing loss).  |                |                            |                              |  |
| Information about you (Please                           | type or pri    | nt in black or blue ink    |                              |  |
| Last name   | First name     |                            | Middle initial               |  |
|   |                |                            |                              |  |
| Birth date  | ļ.             | Sex □ Male □ Femal         | Δ                            |  |
|   |                | Jex   Iviale   Female      |                              |  |
| Home phone number ( )                                   | _              | Mobile phone number (      | _                            |  |
| ☐ I give consent for UnitedHealthcare                   | and its affili | ates to call the phone nur | nber(s) I have provided      |  |
| using an autodialer and/or prerecord                    |                |                            |                              |  |
| Social Security number                                  |                |                            |                              |  |
| •   |                |                            |                              |  |
| (Required for people who are enrolling in D-SNP plans): |                |                            |                              |  |
| Name of skilled nursing facility (if applicable)        |                |                            |                              |  |
|   |                |                            |                              |  |
|   |                |                            |                              |  |
| Envalle e name  |                |                            |                              |  |
| Enrollee name   |                |                            |                              |  |
| Agent name/ID number                                    |                |                            |                              |  |
| UHCSCO_ERF_H2226_2025                                   |                |                            | 1 1107 (201 1101022 1000_001 |  |

| Medicare number  |   |            |            |                                    |
|--|---|------------|------------|------------------------------------|
| Permanent residence street ad homelessness, a PO Box may   | •   |            |            | •                                  |
| City   | County  |            | State      | Zip code                           |
| Mailing address (Only if it's di   | fferent from above. You                             | ı can give | a P.O. box | )                                  |
| City   |   |            | State      | Zip code                           |
| Email address (optional)   |   |            |            |                                    |
| Do you have other insurance (Examples: Other private insurance) programs.) If yes, what is it? Name of other insurance               |   | _          | _          | ☐ Yes ☐ No<br>VA benefits or state |
| name of other insurance  |   |            |            |                                    |
| Member number  | Group number  | Rx         | Bin        | RxPCN (optional)                   |
| Answering these questions is y them out.   | rour choice. You can't b                            | e denied c | overage be | cause you don't fill               |
| A few questions to help u  | ıs manage your plar                                 | 1          |            |                                    |
| 1. Would you prefer plan info  | rmation in another lang                             | juage or a | n accessib | le format?                         |
| If you would prefer plan info<br>you'd like: ☐ Spanish ☐ C<br>Other  | _   | -          |            |                                    |
| If you don't see the language 711, 8 a.m8 p.m. local time  | •   |            |            | •                                  |
| 2. Are you Hispanic, Latino/a  No, not of Hispanic, La  Yes, Mexican, Mexican  Yes, Puerto Rican  Yes, Cuban  Yes, another Hispanic, | tino/a, or Spanish origin<br>American, or Chicano/a | a          | at apply.  |                                    |
| Enrollee name  |   |            |            |                                    |
| Agent name/ID number   |   |            |            |                                    |
| H2226_ERF_2025_C<br>UHCSCO_ERF_H2226_2025  |   |            |            | IMA25HM0221003_001                 |

| I choose not to answer  |  | J                  |
|---|--|--------------------|
| 3. What's your race? Select all that apply.   |  |                    |
| American Indian or Alaska Native  | Black or African American  |                    |
| Asian:  | Native Hawaiian or Pacific Islander:   |                    |
| Asian Indian  | Guamanian or Chamorro  |                    |
| Chinese   | Native Hawaiian  |                    |
| Filipino  | Samoan   |                    |
| Japanese  | Other Pacific Islander   |                    |
| Korean  |  |                    |
| Vietnamese  | White  |                    |
| Other Asian   | I choose not to answer   |                    |
| Member/Citizen of a federal or state  | recognized Tribe (name of Tribe)   |                    |
| 4. Do you or your spouse work?  |  | ☐ Yes ☐ No         |
| (Examples: Other employer group coverage auto liability, or Veterans benefits)  If yes, please complete the following:  Name of health insurance company  Member number  5. Please give us the name of your primary |  | ☐ Yes ☐ No         |
| You can find a list on the plan website or in t   | the Provider Directory.  |                    |
| Provider or PCP full name   |  |                    |
| Provider/PCP number   | (Please enter the number exactly<br>the website or in the Provider Dire<br>10 to 12 digits. Don't include dash | ectory. It will be |
| Are you now seeing or have you recently see   | en this provider? ☐ Yes ☐ No   |                    |
| Please read and sign  |  |                    |
| By completing this form, I agree to the following   | lowing:  |                    |
| <u> </u>  | ealthcare® SCO, is a Medicare Advantage<br>InitedHealthcare® SCO also has a contra                             | •                  |
| Enrollee name   |  |                    |
| Agent name/ID number  |  |                    |
| H2226_ERF_2025_C<br>UHCSCO_ERF_H2226_2025   | UHMA25HM0  | 0221003_001        |

|            | Commonwealth of Massachusetts/MassHealth. This is not a Medicare Supplement plan. I will need to keep my MassHealth Standard plan. I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.   |
|------------|--|
| -          | Because I have MassHealth, I may leave UnitedHealthcare® SCO if I have a qualifying election period. I will no longer be covered by UnitedHealthcare® SCO on the first day of the month following the month I request to leave UnitedHealthcare® SCO. UnitedHealthcare® SCO serves a specific service area. If I move out of the area that UnitedHealthcare® SCO 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 UnitedHealthcare® SCO, I have the right to appeal plan decisions about payment or services if I disagree with them.   |
|            | I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.   |
| <br>       | understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.   |
| t          | understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).   |
| □ <b>I</b> | Release of information: By joining this Medicare Advantage Plan, I acknowledge that the plan 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).  |
| (          | give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.  |
|            | The information on this form is correct to the best of my knowledge. I understand that if I ntentionally provide false information on this form I will be disenrolled from the plan.   |
| i f        | Joining this plan could affect my employer or union health benefits. If I have health coverage from an employer or union, joining this plan may change how my current coverage works. Me or my dependents could lose our other health or drug coverage completely and not get it back if I oin this plan. I will talk to my employer or union. I will ask how joining this plan could affect my current plan. I may also want to check my employer or union's website, or read any information sent to me. If there is no information on whom to contact, my benefits administrator or the office that answers questions about my coverage can help. |
|            | Estate Recovery Awareness: MassHealth is required by federal law to recover money from the   |
| •          | estates of certain MassHealth members who are age 55 years or older, and who are any age   |
|            | ee name  |
| •          | name/ID number<br>_ERF_2025_C  |

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| <ul><li>and are receiving long-term care in a number information about MassHealth estate reduction.</li><li>My response to this form is voluntary. It plan.</li></ul>  | ecovery, p  | ease visit www.mass.  | gov/estaterecovery   |  |  |
|--|---|---|--|--|--|
| When I sign below, it means that I have really I sign as an authorized representative, it is show written proof (power of attorney, guar understand that I will need to submit written behalf of the member beyond this application received my UnitedHealthcare member ID card to update UnitedHealthcare member ID card to update Signature of applicant/member/authorized | neans I ha<br>dianship,<br>n proof of t<br>on. After tl<br>card, I can<br>te my auth                                | ve the legal right under<br>etc.) of this right if Mer<br>this right, to the plan, in<br>his application has be<br>call Customer Service<br>corization information of | er state law to sign. I can<br>dicare asks for it. I<br>if I wish to take action on<br>en approved and I have<br>e at the number on my |  |  |
| If you are the authorized representation below (*Not a Sales Age   | If you are the authorized representative, please sign above and complete the information below (*Not a Sales Agent) |   |  |  |  |
| Last name  |   | First name  |  |  |  |
| Address  |   |   |  |  |  |
| City   | St  | ate   | Zip code   |  |  |
| Phone number ( ) —   |   | Relationship to applicant   |  |  |  |
| 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  | Nationa   | National Producer Number (Agents/Brokers only)  |  |  |  |
| For Licensed Sales Representative/agency use only Licensed Sales representative/Writing ID Initial receipt date  |   |   |  |  |  |
| Enrollee nameAgent name/ID number  |   |   |  |  |  |

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|  |   |                |                   | Page 6 of 8    |
|--|---|----------------|-------------------|----------------|
| Licensed Sales representative/agent name                 |   |                | Proposed effect   | ive date       |
| Agent must complete                                      |   |                |                   |                |
| ☐ IEP (MA-PD   | ☐ ICEP (MA enrollees)                                   |                | P (MA-PD          | □ OEP (Jan 1 - |
| enrollees)   |   | enrol<br>2nd I | lees eligible for | Mar 31)        |
| ☐ OEP (Newly   | ☐ SEP (Dual LIS   |                | EP (Change in     | ☐ SEP (Loss of |
| eligible)  | change of status)                                       |                | ence)             | EGHP coverage) |
| ☐ SEP (Chronic)  | ☐ SEP (Dual LIS   |                | EP (October 15-   | □ OEPI         |
|  | maintaining)  | Dece           | mber 7)           |                |
| ☐ SEP (SEP reason) _                                     |   |                |                   |                |
|  |   |                |                   |                |
| Licensed Sales representative signature (optional)  Date |   |                |                   |                |
|  | Please mail or fax this<br>UnitedHe<br>1325 Boylston St | althca         | re                |                |
|  | Boston, M   |                |                   |                |
|  | Fax: 1-855-   | ·250-2         | 168               |                |
| Fax the front and back of each page                      |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |
|  |   |                |                   |                |

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 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.

UHC Senior Care Options MA-Y001 (HMO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

UnitedHealthcare Senior Care Options is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare and does not have any other comprehensive health insurance, except Medicare. 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 Senior Care Options program. UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-844-560-4944 TTY **711**, daily, 8:00 a.m. to 8:00 p.m.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

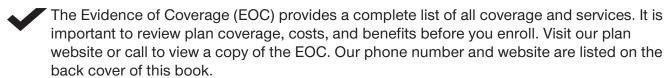
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

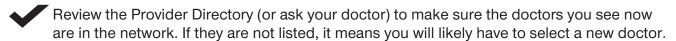
OMB No. 0938-1378 Expires: 6/30/2026 H2226\_ERF\_2025\_C UHCSCO\_ERF\_H2226\_2025

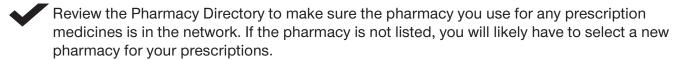
## **Enrollment checklist**

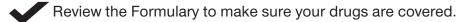
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

## Understanding the benefits

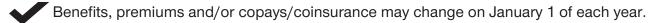


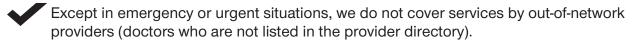


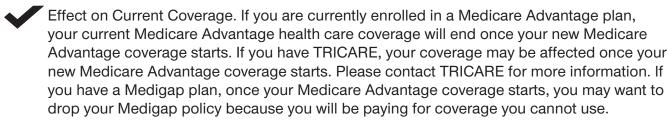




## **Understanding important rules**







This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. To qualify, you must be 65 or older, be eligible to receive Medicare Part A, and be enrolled in Medicare Part B and MassHealth Standard. You may also need to live in your own home or a nursing facility. If you have MassHealth Standard, but you do not qualify for Medicare Part A and/or Medicare Part B, you may still be eligible to enroll.