UCare's Minnesota Senior Health Options (MSHO) (HMO SNP) Enrollment Form

UCare's MSHO Sales: 612-676-3554 or 1-800-707-1711 (toll free)
TTY for the hearing impaired at 612-676-6810 or 1-800-688-2534 (toll free)
8 a.m. to 8 p.m., Monday through Friday

UCare's MSHO Customer Services: 612-676-6868 or 1-866-280-7202 (toll free)
TTY for the hearing impaired at 612-676-6810 or 1-800-688-2534 (toll free)
8 a.m. to 8 p.m., seven days a week

Mailing Address:
P.O. Box 52
Minneapolis, MN 55440
Fax: 612-884-2122

This plan is offered and administered by UCare.
UCare's MSHO is a coordinated care plan with a Medicare Advantage contract and a contract with the Minnesota Medicaid program.

Attention. If you want free help translating this information, call UCare at 612-676-3200 or toll free at 1-800-203-7225.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយ មិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການ ແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣຕາມເລກໂທຣທີ່ຢູ່ຂ້າງ ເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

LB5-0007 (1-08)

This information is available in other forms to people with disabilities by calling: 612-676-3200 (voice) or toll free at 1-800-203-7225 (voice), 612-676-6810 (TTY) or toll free at 1-800-688-2534 (TTY); or through the Minnesota Relay at 711 or toll free direct access at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

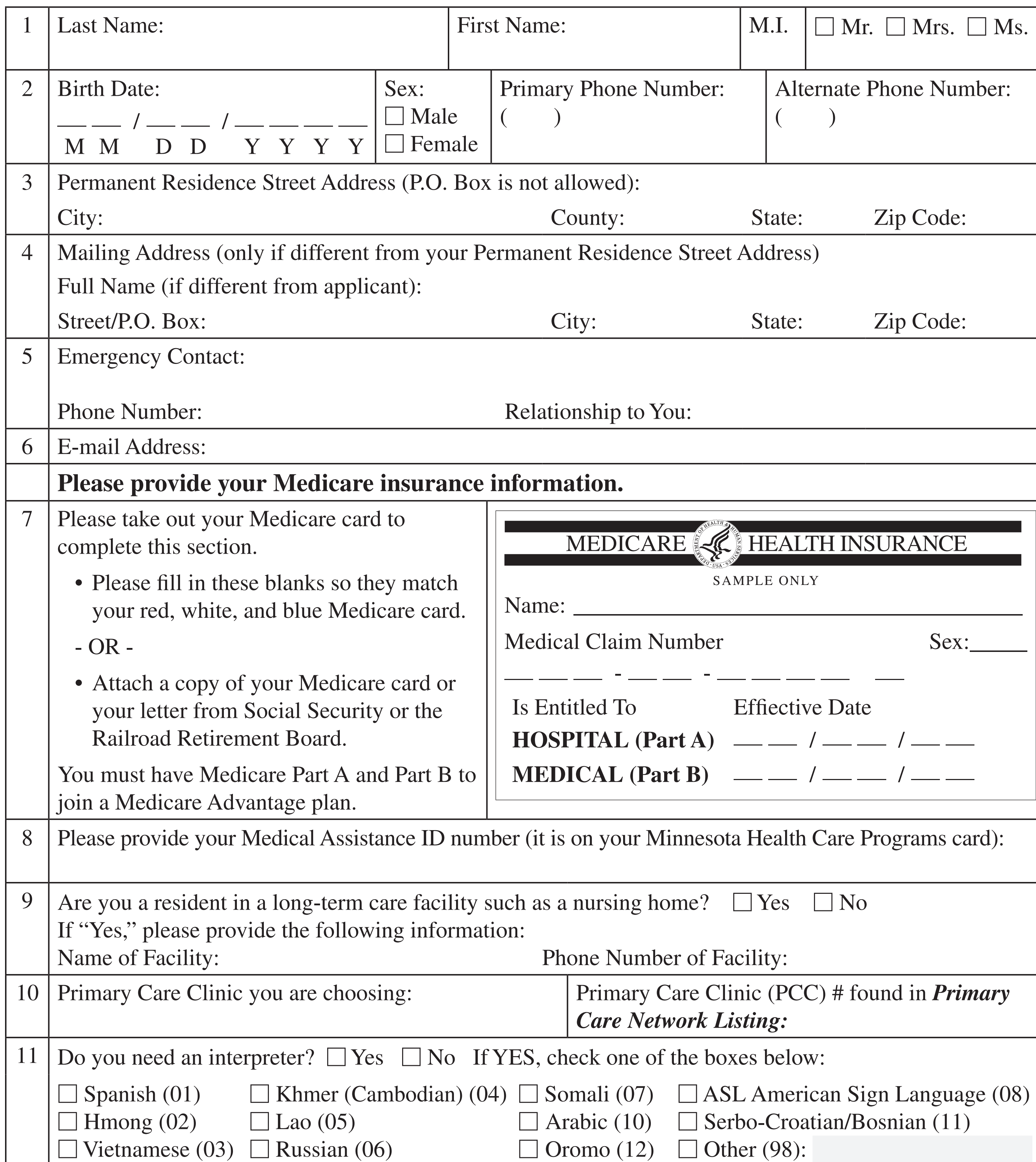
UCare's MSHO has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2014. NCQA's approval is based on a review of UCare's MSHO's Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of UCare's MSHO or the quality of service provided by UCare's MSHO. UCare's MSHO will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 612-676-6868 or 1-866-280-7202 (toll free), 8 a.m. to 8 p.m., daily. TTY: 612-676-6810 or 1-866-280-7202 (toll free).

Copies: White – UCare Yellow – Enrollee

Member Name________________________________ Medical Assistance ID #____________________

UCare's MSHO (HMO SNP) Enrollment Form

To enroll in UCare's MSHO, please provide the following information:



#				
1	Last Name:	First Name:	M.I.	☐ Mr. ☐ Mrs. ☐ Ms.
2	Birth Date: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)	Sex: ☐ Male ☐ Female	Primary Phone Number: ( )	Alternate Phone Number: ( )
3	Permanent Residence Street Address (P.O. Box is not allowed): City: County: State: Zip Code:			
4	Mailing Address (only if different from your Permanent Residence Street Address) Full Name (if different from applicant): Street/P.O. Box: City: State: Zip Code:			
5	Emergency Contact: Phone Number: Relationship to You:			
6	E-mail Address:			
	Please provide your Medicare insurance information.			
7	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 Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: ________ Medical Claim Number __ __ __ - __ __ - __ __ __ __ __ Sex:____ Is Entitled To Effiective Date **HOSPITAL (Part A)** __ __ / __ __ / __ __ **MEDICAL (Part B)** __ __ / __ __ / __ __		
8	Please provide your Medical Assistance ID number (it is on your Minnesota Health Care Programs card):			
9	Are you a resident in a long-term care facility such as a nursing home? ☐ Yes ☐ No If "Yes," please provide the following information: Name of Facility: Phone Number of Facility:			
10	Primary Care Clinic you are choosing:	Primary Care Clinic (PCC) # found in ***Primary Care Network Listing:***		
11	Do you need an interpreter? ☐ Yes ☐ No If YES, check one of the boxes below: ☐ Spanish (01) ☐ Khmer (Cambodian) (04) ☐ Somali (07) ☐ ASL American Sign Language (08) ☐ Hmong (02) ☐ Lao (05) ☐ Arabic (10) ☐ Serbo-Croatian/Bosnian (11) ☐ Vietnamese (03) ☐ Russian (06) ☐ Oromo (12) ☐ Other (98):			

Office use only: Date: ____________ Name of authorized sales person: ______________________

Member Name____ Medical Assistance ID #________________________

12 **Please read and answer these important questions:**

1. Do you have End Stage Renal Disease? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, or VA benefits.

   Will you have other prescription drug coverage in addition to UCare's MSHO? ☐ Yes ☐ No
   If "Yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage: ____________________ ID# for this coverage: ____________________

   Group # for this coverage: ____

3. Do you or your spouse have health insurance, including through a previous or current employer? ☐ Yes ☐ No

   If "Yes", employer/insurer name: ____

   Policy holder's name: ____

   Policy #: ____

Please Read This Important Information

If you currently have health coverage from an employer or union, joining UCare's MSHO could affect your employer or union health benefits. You could lose your employer or union health coverage if you join UCare's MSHO. Read the communications your employer or union sends you. If you have questions, visit their web site, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign on page 3.

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

- UCare's MSHO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B.
- UCare's MSHO will be providing coverage for my care covered by Medicare and Medical Assistance.
- I can be in only one (1) 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 the plan of any prescription drug coverage that I have or may get in the future.
- To be enrolled and stay enrolled in UCare's MSHO, I must meet all the following criteria:
  - Be at least 65.
  - Be eligible for Medical Assistance.
  - Have Medicare Parts A and B.
  - Live in the UCare's MSHO service area.

  If any of this changes, I will notify UCare's MSHO so I can disenroll and find a new plan.

- I can choose to leave UCare's MSHO at any time. I understand that I will be enrolled in UCare's MSHO through the last day of the month. I understand that I will be automatically enrolled in the Minnesota Senior Care Plus (MSC+) plan, which will cover my Medical Assistance benefits. If I request in writing, I will be enrolled in my previous MSC+ plan.
- Once I am a member of UCare's MSHO, I have the right to appeal plan decisions about payment or services if I disagree.
- I will read the ***Evidence of Coverage*** from UCare's MSHO when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.
- I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that beginning on the date UCare's MSHO coverage begins, I must get all of my health care from UCare's MSHO network providers, except for emergency or urgently needed services, out-of-area or out-of-network dialysis services, **open access** services, or any services previously authorized. Services authorized by UCare and other services contained in my UCare's MSHO ***Evidence of Coverage*** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR UCARE WILL PAY FOR THE SERVICES.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with UCare, he/she may be paid based on my enrollment in UCare's MSHO.
- If I obtain a medical spenddown while enrolled in UCare's MSHO and do not pay it to DHS, I will be disenrolled from UCare's MSHO.
- If I am now getting Elderly Waiver services through the county, I am aware that my case manager may be replaced by a different county case manager or a health plan care coordinator.

Release of information: By joining UCare's MSHO, I acknowledge that:

- UCare will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations.
- UCare will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations.
- By enrolling in UCare's MSHO, I authorize the State to give information about my Medicare and Medical Assistance status and the information on this form to its representatives, the county where I live now, and to UCare.
- 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 my behalf under the laws of the State where I live) 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 by State law to complete this enrollment form, and
2. Documentation of this authority is available upon request from Medicare.

<table>
<tr><td colspan="2">Name of Applicant (please print):</td></tr>
<tr><td>Signature:</td><td>Today's Date:</td></tr>
<tr><td colspan="2">If you are the authorized representative, you must sign above and provide the following information:</td></tr>
<tr><td>Name (print):</td><td>Relationship to Enrollee:</td></tr>
<tr><td>Address (print):</td><td>Telephone Number:</td></tr>
</table>

Instructions

For filling out the UCare's MSHO Enrollment Form

Please print as neatly as possible.
Please fill in the following information by numbered line on your enrollment form.

1	Name:	Write your name (last name, first name, middle initial).
2	Birth Date: Sex: Phone Number: Alternate Phone Number:	Write the month, day, and year you were born. Check the box indicating if you are male or female. Write the telephone number where you can be reached during the day.
3	Permanent Residence Street Address:	Write in the permanent address where you live, including street address, city, county, state, and zip code (no P.O. boxes).
4	Mailing Address Full name (if different than applicant):	Write in the address where you receive your mail, if different from your permanent street address. Please also include the full name of the resident at this address, if different than the applicant.
5	Emergency Contact:	Write in the name and phone number of the person you would like us to contact in the event of an emergency. Please also tell us what that person's relationship is to you.
6	E-mail Address:	Write in your e-mail address.
7	Medicare Number: Effective Date Hospital (Part A): Effective Date Medical (Part B):	Take out your Medicare card to complete this section. Write your Medicare number as it appears on your red, white, and blue card (not your social security card). Write in the effective date for Hospital (Part A) as it appears on your card. Write in the effective date for Medical (Part B) as it appears on your card.
8	Medical Assistance ID Number:	Write in your Medical Assistance number.
9	Are you a resident in a long-term care facility?	If you now live in a long-term care facility, such as a nursing home or ICF-DD, check "Yes" and write in the name, address, and phone number. If you do not, check "No."
10	Primary Care Clinic: Primary Care Clinic #:	Go to the health plan's ***Primary Care Network Listing*** in your information packet. Write in the Primary Care Clinic that you choose. Write the code of the Primary Care Clinic that you choose, located in the ***Primary Care Network Listing.***
11	Do you need an interpreter?	Check "Yes" or "No." If you answer "Yes," check the box to the left of the language needed on the list.

12	1. End Stage Renal Disease: 2. Other prescription drug coverage: 3. Other health insurance:	Check “Yes” or “No.” If you answered “Yes” to this question, please fill out the name of the other coverage, the ID number, and Group number. If you answered “Yes” to this question, please fill out the employer/insurer name, policy holder’s name, and policy number.

Page 3 should be signed and filled out by you or your authorized representative.