



Expansion Enrollment Form

UCare Connect (Special Needs BasicCare)

UCare Connect Sales: 612-676-3554 or 1-800-707-1711 (toll free)

TTY: 612-676-6810 or 1-800-688-2534 (toll free)

8 a.m. to 8 p.m., Monday through Friday

UCare Connect Customer Services: 612-676-3395 or 1-877-903-0061 (toll free)

TTY: 612-676-6810 or 1-800-688-2534 (toll free)

7:45 a.m. to 5 p.m., Monday through Friday

This plan is offered and administered by UCare.

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 បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ 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. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທອຕາມເລກໂທອທີ່ຢູ່ຂ້າງເທິງນີ້.

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.

LB5-0009 (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.

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Last Name:		First Name:			M.I.				
Birth Date: ____ / ____ / ____ M M D D Y Y Y Y		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	County you live in:	Social security number (optional):	Home phone: ()				
Street address:		City:	State:	Zip Code:					
Mailing address (if different from where you live):		City:	State:	Zip Code:					
Case number:	Medical Assistance ID #:		E-mail address (optional):						
<p>Do you need an interpreter? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please check one of the boxes below:</p> <p><input type="checkbox"/> Spanish (01) <input type="checkbox"/> Hmong (02) <input type="checkbox"/> Vietnamese (03) <input type="checkbox"/> Khmer (Cambodian) (04) <input type="checkbox"/> Lao (05)</p> <p><input type="checkbox"/> Russian (06) <input type="checkbox"/> Somali (07) <input type="checkbox"/> American Sign Language (08) <input type="checkbox"/> Arabic (10)</p> <p><input type="checkbox"/> Serbo-Croatian/Bosnian (11) <input type="checkbox"/> Oromo (12) <input type="checkbox"/> (98) Other, explain _____</p>									
Do you have a disability that has been certified by the Social Security Administration or State Medical Review Team (SMRT)? <input type="checkbox"/> YES <input type="checkbox"/> NO				Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO					
<p>Some individuals may have other medical coverage, including other private insurance.</p> <p>Do you have other medical coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, provide information about your other coverage below:</p> <table border="1"> <tr> <td>Insurance company name:</td> <td>Group # for this coverage:</td> </tr> <tr> <td>Policy holder's name:</td> <td>Policy/ID number:</td> </tr> </table>						Insurance company name:	Group # for this coverage:	Policy holder's name:	Policy/ID number:
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Policy holder's name:	Policy/ID number:								
CHOOSE HOW YOU WILL GET YOUR HEALTH CARE.									
<p>You do not have to join <i>UCare Connect</i>, a Minnesota Health Care Programs Special Needs BasicCare (SNBC) plan. You can keep getting your health care from Medical Assistance (MA) fee-for-service. Remember, if you do join <i>UCare Connect</i> and you do not like the program, you may drop out and change back to MA fee-for-service, effective the first of the following month.</p>									
Primary care clinic you are choosing:				Primary care clinic number: _____					

Names and numbers of your choices for a primary care clinic can be found in the *UCare Connect Primary Care Network Listing*, or online at www.ucare.org.

Please read and sign the back of this form.

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

UCare Connect will be providing my health care covered by Medical Assistance.
Once I am a member of UCare Connect, I have the right to appeal any services that are being denied, reduced, or stopped, or if UCare is denying payment for services.
I will be notified of the date my coverage will start.
If I do not receive all of my covered health care from UCare's network providers, then UCare will not pay for services, except in an emergency, or for urgently needed services.
I will read the Evidence of Coverage I get from UCare; it will have the rules I must follow and more information about covered services authorized by UCare. Services authorized by UCare and other services contained in my UCare Connect Evidence of Coverage will be covered. Without authorization, UCARE WILL NOT PAY FOR THE SERVICES.
My UCare Connect benefits cannot be canceled because I get sick or use health care services.
I can choose to leave UCare Connect and change back to Medical Assistance fee-for-service, effective the first of the following month.
I must choose a primary care clinic. My health care services will be coordinated by UCare.
To be enrolled and stay enrolled in UCare Connect, I must: <ul style="list-style-type: none">• Be certified as disabled by the Social Security Administration or State Medical Review Team (SMRT).• Be under age 65 at the time of enrollment.• Be eligible for Medical Assistance.• Either have no Medicare, OR have both Medicare Parts A and B.• Live in a county served by UCare Connect. If any of these things changes, I will notify my worker and UCare so I can disenroll.

By enrolling in this health plan, I authorize:

The State to give information about my Medical Assistance eligibility and the information on this form to its representatives, the county where I live, and UCare.
The information on this form is correct to the best of my knowledge.

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 form means that I have read and understand the contents of this form. 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 form on my behalf, and 2) I will provide documentation of this authority upon request by the State or UCare.

Signature of enrollee or authorized representative:		Date:
If you are the authorized representative, you must sign above and provide the following information.		
Name (please print):		
Relationship to enrollee:	Phone: ()	
Address:		
City:	State:	ZIP Code:

Please return this form in the enclosed envelope by mail to:

**UCare
P.O. Box 52
Minneapolis, MN 55440**

You can also fax this form to UCare at **612-884-2122**.