

# INSTRUCTIONS FOR COMPLETING YOUR ONE CARE ENROLLMENT DECISION FORM

## IMPORTANT!

The One Care Enrollment Decision Form asks you to make a decision about whether you want to get your MassHealth and Medicare coverage through a One Care plan. You have the right to ask questions before deciding if One Care is right for you. *You will keep your Medicare and MassHealth benefits if you join a One Care plan.*

One Care plans will cover all of your Medicare, MassHealth, and prescription drug benefits, including Medicare Part D. One Care plans will also provide care coordination and access to community-based services as described in the One Care Enrollment Guide. The One Care Enrollment Guide can be downloaded from the One Care website at: [www.mass.gov/one-care](http://www.mass.gov/one-care).

For more information:

- ▶ visit the One Care website at: [www.mass.gov/one-care](http://www.mass.gov/one-care)
- ▶ visit the One Care plans' websites:
  - ◆ Commonwealth Care Alliance: [www.commonwealthonecare.org](http://www.commonwealthonecare.org)
  - ◆ Tufts Health Plan: [www.ChooseUnify.org](http://www.ChooseUnify.org)
  - ◆ UnitedHealthcare Connected: [www.uhccommunityplan.com/ma](http://www.uhccommunityplan.com/ma)

## You can tell us if you want to enroll in One Care by filling out this *One Care Enrollment Decision Form*

Use this form to:

- ▶ Sign up for a new One Care plan
- ▶ Move from the One Care plan you have now to a different One Care plan, if available
- ▶ Decide you no longer want to be enrolled in One Care. Your coverage in One Care will end on the last day of the month.
- ▶ **IMPORTANT:** If you got a letter from MassHealth telling you that you are being enrolled in a One Care plan, you can also use this form to choose a different plan or to tell us you don't want to be enrolled in One Care. You have 60 days from the date you got the first letter to fill out this form and make a different choice before your enrollment in One Care takes effect.

## How to complete the One Care Enrollment Decision Form

### To join One Care or change One Care plans:

Check the box next to the One Care plan that you would like to join.

- ▶ **IMPORTANT:** You can only choose a One Care plan that is in your county.
- ▶ To find out which plans are available in your county, check the "One Care Plans" page on the One Care website at: [www.mass.gov/one-care](http://www.mass.gov/one-care).

OR

### If you don't want to be in One Care:

Check the box next to the words "I do not want to sign up for One Care."

- ▶ If you check this box and you are not in a One Care plan, you will keep getting your care the same way you do now.
- ▶ If you check this box and you are enrolled in a One Care plan, you will go back to MassHealth and Original Medicare.

**If you have questions**, call MassHealth Customer Service (Monday–Friday, 8:00 a.m.–5:00 p.m.): 1-800-841-2900 or TTY: 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled).

If you require a special accommodation to communicate with us, you may contact MassHealth Customer Service or the MassHealth Disability Accommodations Ombudsman at 617-847-3468 or TTY: 617-847-3788.

This information is also available online at [www.mass.gov/one-care](http://www.mass.gov/one-care).



## ONE CARE ENROLLMENT DECISION FORM

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Please print your

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

Daytime phone number: \_\_\_\_\_

Date of birth: (MM/DD/YYYY): \_\_\_\_\_ Sex:  F  M

Do you have end-stage renal disease (ESRD)?  Yes  No

MassHealth ID number: \_\_\_\_\_

Medicare number (found on your red, white and blue Medicare card): \_\_\_\_\_

### Other Health Care Coverage

Some people have other health insurance or drug coverage through private insurance, TRICARE, employers, unions, Veterans Affairs, or the State Pharmaceutical Assistance Program.

Do you have other health coverage besides MassHealth and Medicare?  Yes  No

If yes, fill in the information below.

Name of your plan (and employer, if applicable): \_\_\_\_\_

Group number: \_\_\_\_\_ ID number: \_\_\_\_\_

Name of your plan (and employer, if applicable): \_\_\_\_\_

Group number: \_\_\_\_\_ ID number: \_\_\_\_\_

If you have other health coverage, you may not be able to sign up for One Care.

### YOUR ENROLLMENT DECISION

Please check **one** of the boxes below to tell MassHealth your enrollment decision.

Tufts Health Plan

Commonwealth Care Alliance (CCA)

UnitedHealthcare Connected

I do not want to sign up for One Care. (If you are not in One Care, this means you will keep getting your care the same way you do now; if you are currently in One Care, you will go back to MassHealth and Original Medicare.)

**Please complete the front and back of this form and return it in the enclosed envelope to MassHealth:**

**Mailing Address:**

OR

**Fax Number:**

Health Insurance Processing Center  
ATTN: One Care Enrollment  
PO Box 4405  
Taunton, MA 02780

617-988-8975

Please return both pages of this *One Care Enrollment Decision Form* to MassHealth.

**Please read and sign below.**

When you sign this form, it means that you understand the following.

- ▶ One Care plans have a contract with the federal government and with Massachusetts.
- ▶ The health services I get with my new plan may be different than the services I had before.
- ▶ I must keep Medicare Part A, Part B, and MassHealth.
- ▶ I can be in only one Medicare plan at a time.
- ▶ By joining a One Care plan I will end my enrollment in another Medicare health or prescription drug plan.
- ▶ I must tell Medicare and MassHealth about any prescription drug coverage that I have or may get in the future.
- ▶ If I move, I need to tell MassHealth.
- ▶ As a member of a One Care plan, I have the right to appeal if I don't agree with my One Care plan's decisions about payment or services.
- ▶ The One Care plans do not usually cover people while they're out of the country.
- ▶ On the date my One Care plan coverage begins, I will have access to my current doctors for 90 days. Beyond 90 days, I must get my health care from my One Care plan's providers and pharmacies, except for emergency or urgently needed care, out of area dialysis, or if I get my One Care plan's approval to see other providers in some circumstances. My One Care plan will help me find new providers if I need them.
- ▶ If I need to see a doctor or other provider who is not in my One Care plan, I may need prior authorization or I may have to pay out-of-pocket for the services I get.
- ▶ I understand that if a sales agent employed by the One Care plan helps me enroll, the One Care plan may pay that person.
- ▶ By joining a One Care plan, I know that the One Care plan may share my information with Medicare and MassHealth and other plans as necessary for treatment, payment, and health care operations.
- ▶ I understand that prescription drugs are covered, but not always the same ones I'm already taking. I understand that I'll have access to my current drugs for at least 30 days, until I can switch to a different drug.
- ▶ I know that my One Care plan may share my information, including my prescription drug information, with Medicare and MassHealth. They may release it for research and other purposes, as allowed by federal or state statutes and regulations.
- ▶ The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I'll be disenrolled from my One Care plan.
- ▶ My signature (or my authorized representative's signature) on this form means that I've read and understood this form. If an authorized representative signs, the person's signature means that he or she is authorized under state law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or MassHealth.

**Your signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are the authorized representative, you must provide the following information, and sign and date below.

Name (Please print): \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship to enrollee: \_\_\_\_\_ Today's date: \_\_\_\_\_