



Thank you for applying for membership in NaviCare HMO SNP. Please fill out the entire enrollment form and sign it. If we receive an incomplete form, it may not be processed until we receive additional information from you. (Remember to press firmly when filling out the enrollment form.)

**This checklist is to help make sure you have completed the enclosed enrollment form.**

**Have you filled out the following information?**

- Your MassHealth ID number
- Your full legal name
- Your date of birth
- Your sex (male or female)
- Your telephone number
- Your permanent home address
- Your mailing address (if different from your home address)
- Your end-stage renal disease (ESRD) status
- Your Medicare information, if you have Medicare coverage. (In order for your enrollment to be complete, you must either copy information from your Medicare card or you may attach a photocopy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. If you do not have your Medicare information or have not been assigned a Medicare claim number at this time, call your local Social Security office to enroll or obtain proof of enrollment.)
- If someone helped you fill out this enrollment form, this person must sign the form and provide his or her relationship to you, his or her address, and his or her phone number.

After reading through your enrollment form, please remember to sign and date your enrollment form. Pull out the pink copy of your signed and dated enrollment form for your records. Return the rest of the form in the enclosed postage-paid envelope. If you misplaced the postage-paid envelope, mail your enrollment form to:

**NaviCare  
Fallon Community Health Plan  
10 Chestnut St.  
Worcester, MA 01608**

**or you may fax it to us at 1-508-368-9981.**

**MassHealth Information**

Are you enrolled in MassHealth? Yes  No

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

\_\_\_\_\_ MassHealth ID Number

**You must have MassHealth Standard benefits to enroll in a senior care organization.** To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss.)

Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure. Yes  No   
Generally, if you answered yes to this question, you cannot enroll in SCO.

However, if you answered yes to this question and you do not need regular dialysis anymore or have had a successful kidney transplant, please attach a note from your doctor indicating that either you no longer need dialysis or have had a successful kidney transplant.

**Name of primary care doctor you have selected**

\_\_\_\_\_

**Member information**

Last Name	First Name	MI	Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/>
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Format for materials <input type="checkbox"/> Braille <input type="checkbox"/> Audio cassette <input type="checkbox"/> Large Print	
Written Language Preferred		Spoken Language Preferred	

**Permanent Address** (where you live)

Street Address		City/Town
State	Zip Code	Telephone Number

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

Street Address		City/Town
State	Zip Code	Telephone Number

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

Name \_\_\_\_\_


Street Address		City/Town
State	Zip Code	Telephone Number

## Medicare Information

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 the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE				HEALTH INSURANCE	
SAMPLE ONLY					
Name: _____					
Medicare Claim Number			Sex ____		
_____ - _____ - _____			_____		
Is Entitled To			Effective Date		
<b>HOSPITAL (Part A)</b>			_____		
<b>MEDICAL (Part B)</b>			_____		

## 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?

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## Your Medical Care

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

This senior care organization NaviCare HMO is a Medicare Advantage plan and has a contract with the federal government. NaviCare HMO 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 NaviCare HMO at any time. I will no longer be covered by NaviCare HMO on the first day of the month following the month I request to leave NaviCare HMO. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

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

Please go to the next page. ►

## 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 this senior care organization (NaviCare HMO) 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 the contents of this application. 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 and 2) documentation of this authority is available upon request by NaviCare HMO 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; or \_\_\_\_\_ evening.*

## Signature

Signature: \_\_\_\_\_ 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: \_\_\_\_\_

**If you need further information to complete this enrollment form, please call us at 1-877-700-6996 (TDD/TTY: 1-877-795-6526), Monday through Friday, 8 a.m. to 8 p.m. (From October 15 – February 14, we're available seven days a week.)**

Once we have received your completed enrollment form, a NaviCare representative may call you to make sure you understand how our plan works, and to answer any questions you may have.

*A Coordinated Care plan with a Medicare Advantage contract and a contract with the Massachusetts Medicaid program. NaviCare HMO SNP is a voluntary program in association with MassHealth/EOHHS and CMS. NaviCare HMO SNP is available to individuals age 65 and older who have Medicare Parts A and B and MassHealth Standard and live in the service area. NaviCare SCO is available to individuals age 65 and older who have MassHealth Standard and live in the service area. (Individuals with MassHealth Standard do not have to be covered by Medicare Parts A and B to enroll in NaviCare SCO.) Eligible beneficiaries may enroll in NaviCare HMO SNP or NaviCare SCO at any time. Except in emergent and urgent care situations, you must use network pharmacies to access the prescription drug benefit. Quantity limits and restrictions may apply. You must receive all routine care from plan providers. NaviCare HMO SNP 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 NaviCare'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 NaviCare or the quality of service provided by NaviCare. NaviCare 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 1-877-700-6996.*

## Office Use Only

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

Plan ID No.: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_

SEP (type): \_\_\_\_\_ Not Eligible: \_\_\_\_\_

NOTES