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

UCare's MSHO Enrollment and Medical and Prescription Drug question Telephone Numbers

612-676-3554 or 1-800-707-1711

TTY for the hearing impaired
at 612-676-6810 or 1-800-688-2534
8 am – 5 pm, Monday – Friday.

The call is free.

UCare's MSHO Customer Service Telephone Numbers

612-676-6868 or 1-866-280-7202

TTY for the hearing impaired
at 612-676-6810 or 1-800-688-2534
8 am – 8 pm, seven days a week.

The call is free.

Return the completed form, pages 1 to 4, to:

UCare
PO Box 52
Minneapolis, MN 55440
Fax: 612-884-2122

Please contact UCare's MSHO Customer Service at the number listed above if you need information in another language or format.

UCare's Minnesota Senior Health Options (MSHO) (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UCare's MSHO depends on contract renewal.

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 elders 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.

Member Name: _____ Medical Assistance ID #:_____

UCare's MSHO (HMO D-SNP) Enrollment Form

To join UCare's MSHO, you must have **Medicare Part A, Medicare Part B,** and **Medical Assistance without a medical spenddown, and** be age 65 or over, **and** live in UCare's MSHO's service area. You must also be a United States citizen or be lawfully present in the U.S.

Section 1. Tell us about yourself:

1	**Name: (first, middle, last)**			
2	**Date of Birth:** **(___ ___ / ___ ___ / ___ ___ ___ ___)** **M M D D Y Y Y Y**		**Sex: ☐ Female ☐ Male**	
3	**Phone number:** **( ) _____ - _____**		**Another phone number (Optional):** **( ) _____ - _____**	
4	**Address where you live (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO box may be considered your permanent residence address.):**			
	City:	**State:**	**ZIP Code:**	**County:**
5	**Address where you get mail (if different from where you live):**			
	City:	**State:**	**ZIP Code:**	**County:**
6	**Do you live in a long-term care facility? ☐ Yes ☐ No If Yes, fill in the information below:** **Name of the facility:** **Phone number:** **( ) _____ - _____**			
7	**Do you need an interpreter? ☐ Yes ☐ No If Yes, check the language below:** **☐ 01 Spanish ☐ 02 Hmong ☐ 03 Vietnamese ☐ 04 Khmer (Cambodian) ☐ 05 Lao ☐ 06 Russian** **☐ 07 Somali ☐ 08 ASL (American Sign Language) ☐ 09 Amharic ☐ 10 Arabic ☐ 12 Oromo ☐ 14 Burmese** **☐ 15 Cantonese ☐ 16 French ☐ 20 Korean ☐ 21 Karen ☐ 98 Other:** **_____**			

Section 2. Tell us more about yourself:
You are not required to answer questions or give any information in this section. It's your choice to share this information with us. We can't deny you coverage if you don't answer them.

8	**Do you want us to send you information in a language other than English? ☐ Yes ☐ No** **If Yes, write language: _____**

Member Name: _____ Medical Assistance ID #:_____

9	**Do you want us to send you information in an accessible format? ☐ Yes ☐ No** **If Yes, check format below.** **☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD** Please contact UCare's MSHO at 612-676-6868 or 1-866-280-7202 if you need information in an accessible format other than what's listed above. Our office hours are 8 am – 8 pm, seven days a week. TTY users can call 612-676-6810 or 1-800-688-2534.
10	**Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.** **☐ No, not of Hispanic, Latino/a, or Spanish origin** **☐ Yes, Puerto Rican** **☐ Yes, another Hispanic, Latino/a or Spanish origin** **☐ Yes, Mexican, Mexican American, Chicano/a** **☐ Yes, Cuban** **☐ I choose not to answer**
11	**What's your race? Select all that apply.** **☐ American Indian or Alaskan Native** **☐ Chinese** **☐ Japanese** **☐ Other Asian** **☐ Vietnamese** **☐ Asian Indian** **☐ Filipino** **☐ Korean** **☐ Other Pacific Islander** **☐ White** **☐ Black or African American** **☐ Guamanian or Chamorro** **☐ Native Hawaiian** **☐ Samoan** **☐ I choose not to answer**
12	**What is your gender? Select one.** **☐ Woman ☐ Man ☐ Non-binary ☐ I use a different term _____** **☐ I choose not to answer**
13	**Which of the following best represents how you think of yourself? Select one:** **☐ Lesbian or gay ☐ Straight, that is, not gay or lesbian ☐ Bisexual** **☐ I don't know ☐ I use a different term _____** **☐ I choose not to answer**
14	**Do you want to get information by email? ☐ Yes ☐ No** **If Yes, provide your email address below.** **Email:**_____
15	**Do you work? ☐ Yes ☐ No** **Does your spouse or domestic partner work? ☐ Yes ☐ No ☐ Does not apply**
16	**Name of the primary care clinic/care system you are choosing:**

Section 3. Tell us about your Medicare and Medical Assistance coverage:

Fill in your Medicare and Minnesota Health Care Program (MHCP) information below. You can find Medicare information on your red, white, and blue Medicare card or in a letter from Social Security or the Railroad Retirement Board. Also, please put your Minnesota Health Care Program (MHCP) Member Number as it appears on the front of your card. This is also known as your Medical Assistance Member Number.

17	**Medicare Number:** _____	**MHCP ID Number:** _____

Member Name: _____ Medical Assistance ID #:_____

Section 4. Tell us about your health coverage including your prescription drug coverage:
Some people have other health insurance or drug coverage through private insurance, TRICARE, Employers, Unions, Veterans Affairs, or the State Pharmaceutical Assistance Programs.

18	**Do you have other health coverage? ☐ Yes ☐ No If Yes, fill in the information below:**	
19	**Name of your plan (and employer, if applicable):**	**Group number:**
		Policy or ID number:

If you have health coverage from an employer or union right now, you or your dependents could lose that coverage when you join UCare's MSHO. Your employer or union can give you more information about your coverage. If you have questions, talk with the person in your office who takes care of benefits.

Section 5. Tell us about your enrollment eligibility.
20. Please read the following statements carefully and check the box if the statement applies to you.
Check all that apply. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am applying during the Medicare Advantage plan annual enrollment period from October 15 through December 7 and want my enrollment effective January 1.

☐ I am new to Medicare.

☐ I have both Medicare and Medical Assistance (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I recently had a change in my Medical Assistance (newly got Medical Assistance or had a change in level of Medical assistance) on (date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved or will move into or out of the facility on (date) _____.

☐ I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (date) _____.

☐ I am leaving employer or union coverage on (date) _____.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (date) _____.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (date) _____.

☐ I recently was released from incarceration. I was released on (date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (date) _____.

Member Name: _____ Medical Assistance ID #:_____

☐ I recently obtained lawful presence status in the United States. I got this status on (date) _____.

☐ I was affected by a weather-related emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact UCare's MSHO at 1-800-707-1711 (TTY users should call 1-800-688-2534) to see if you're eligible to enroll. We are open 8 am – 5 pm, Monday – Friday.

Please read the information on page 5 and sign below.
When you sign this form, it means that you understand the information you read.

_____
Name of Applicant (Please print)

_____ _____
Signature Today's Date

If you are the authorized representative, **you must sign above** and provide the following information.

_____ _____
Name (Print) Relationship to Enrollee

_____ _____
Address (Print) Telephone Number

When the form is completed, mail or fax it to UCare's MSHO. Our address and fax number are on the cover.

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: _____

National Producer Number (Agents/Brokers only): _____

Office use only:

Date:_____ Name of Authorized Sales Person:_____

Broker ID number: _____ Effective Date of Enrollment _____

Election Code_____ Approved by _____

Information and Acknowledgement Statements

- My response to this form is voluntary. I understand that my enrollment in UCare's MSHO may be affected if I don't respond.
- I must keep Medicare Part A and Part B and Medical Assistance to stay in UCare's MSHO.
- I understand that I can be enrolled in only one MA plan at a time — and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- By joining UCare's MSHO, 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 collection of this information (refer to the Privacy Act Statement below).
- I understand that when my UCare's MSHO coverage begins, I must get my medical and prescription drug benefits from UCare's MSHO.
- Benefits and services provided by UCare's MSHO and contained in my *Member Handbook* are covered. Neither Medicare nor UCare's MSHO will pay for benefits or services that are not covered.
- I understand that UCare's MSHO doesn't usually cover people while they're out of the country except under limited circumstances.
- I can choose to leave UCare's MSHO any month of the year. 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 ask in writing, I will be enrolled in my previous MSC+ plan.
- If I get a medical spenddown while enrolled in UCare's MSHO and do not pay it to the State, I will be disenrolled from UCare's MSHO.
- 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 my signature (or my authorized representative's signature) on this form means that I've read and understand the contents of this form. If an authorized representative signs, the person's signature means that they are authorized under State law to complete this enrollment, and documentation of this authority is available upon request from Medicare and/or Medical Assistance.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 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.

Pre-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 612-676-6868 or 1-866-280-7202 (TTY users call 612-676-6810 or 1-800-688-2534), 8 am – 8 pm, seven days a week.

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.

Additional requirements are:

- You live in UCare's MSHO service area
- You have both Medicare Part A and Medicare Part B
- You are a United States citizen or are lawfully present in the United States
- You are age 65 or over

Understanding the Benefits

- ☐ The Member Handbook provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **ucare.org/formembers** or call 612-676-6868 or 1-866-280-7202 (TTY users call 612-676-6810 or 1-800-688-2534) to view a copy of the Member Handbook.
- ☐ Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary (list of covered drugs) to make sure your drugs are covered.

Understanding Important Rules

- ☐ Benefits and/or copays may change on January 1, 2026.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).

Toll free 1-800-203-7225, TTY 1-800-688-2534

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ပက်သူဉ်ပက်သးဘဉ်တက့်။ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤနူဉ်တက့်။

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. UCare does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Toll Free: 1-800-203-7225
TTY: 1-800-688-2534
Fax: 612-884-2021
Email: cag@ucare.org

Auxiliary Aids and Services: UCare provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Language Assistance Services: UCare provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** UCare at 612-676-3200 (voice) or 1-800-203-7225 (voice), 612-676-6810 (TTY), or 1-800-688-2534 (TTY).

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UCare. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll-free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service