NaviCare®
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 1-877-255-7108 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (Oct. 1–March 31, seven days a week).

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage (EOC)*, especially for those services for which you routinely see a doctor. Visit fallonhealth.org/navicare or call 1-877-255-7108 (TRS 711) to view a copy of the *EOC*.

- ☐ Review the provider 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 pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium unless the Commonwealth of Massachusetts pays this premium for you. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.

- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

- ☐ 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. You are eligible for NaviCare if you are 65 or older, live in our service area (all of MA, except Dukes and Nantucket counties) and are eligible for MassHealth Standard.

fallon health

NaviCare is a voluntary program in association with MassHealth/EOHHS and CMS.

This form is for people who have MassHealth Standard benefits and Medicare Parts A and B, and choose to enroll in NaviCare®.

MassHealth Senior Care Options (SCO) & Medicare Advantage Enrollment Form

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 be 65 years or older, have MassHealth Standard benefits, live in the NaviCare ***service area, not have other comprehensive health insurance (except Medicare) and not be a resident of a chronic hospital, to enroll in a senior care organization.*** To apply for MassHealth, call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

▶ **Name of primary care doctor you have selected:** _____

Member Information

Last name	First name	MI	Mr. ☐ Mrs. ☐ Ms. ☐
Date of birth	Sex M ☐ F ☐	Preferred format for materials ☐ Braille ☐ Large print ☐ CD ☐ Other _____	
Written language preferred	Spoken language preferred		

Permanent address (where you live)

Street address		City/town
State	ZIP	Telephone number

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

Street address		City/town
State	ZIP	Telephone number

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

Name of nursing facility		
Street address		City/town
State	ZIP	Telephone number

Please go to the next page. ▶

Medicare Information

▶Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your 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.

Name (as it appears on your Medicare card):

_____

Medicare Number:

_____

Is entitled to: Effective date:

❑ HOSPITAL (Part A) _____

❑ MEDICAL (Part 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? _____

Your Medical Care

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

Fallon Health is a Medicare Advantage plan and has a contract with the federal government. Fallon Health 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 and Medicare Parts A and B, I may leave NaviCare HMO SNP or make changes only at certain times of the year when an enrollment period is available (Example: Because you have MassHealth, once per calendar quarter during the first nine months of the year), or under other certain special circumstances.

Because I have MassHealth and not Medicare Part A and/or B, I may leave NaviCare SCO at any time. I will no longer be covered by NaviCare SCO on the first day of the month following the month I request to leave NaviCare SCO. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

NaviCare serves a specific service area. If I move out of the area that NaviCare 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, 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 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 coverage begins, I must get all my health care from NaviCare with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by NaviCare and other services contained in my NaviCare

Please go to the next page. ▶

Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR NAVICARE 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, he or she may be compensated based on my enrollment in NaviCare.

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 NaviCare HMO SNP 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 SNP 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*** _____ ***evening***

Signature

Signature: _____

Print name: _____

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: _____

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