TUFTS Health Plan

Scope of Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires licensed sales agents to document the scope of the products that may be presented during a marketing appointment between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare eligible beneficiary or his/her authorized representative.

To be completed by person with Medicare and Medicaid, or his/her authorized representative

Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):

- ☐ Medicare Advantage Plans (Part C)
- ☐ Medicare Supplement or (Medigap) Products
- ☑ Medicare Special Needs Plan (SNP)
- ☐ Medicare Prescription Drug Plan (PDP)

Beneficiary or authorized representative signature and signature date

By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you indicated above. Please note, the individual who will discuss the products is either employed or contracted by a Medicare plan. They **do not** work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form **does not obligate** you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Signature

If you are the authorized representative, please sign and print below.

Date

Representative's name

Relationship to beneficiary

To be completed by the agent

Agent name

Agent phone

Agent writing number

Date appointment will be completed

Beneficiary name

Beneficiary phone

Street

City/State/Zip

Initial method of contact

Agent's signature

Plans the agent will represent during the meeting:

- [ ] Medicare Advantage Plans (Part C)
- [ ] Medicare Supplement or (Medigap) Products
- [x] Medicare Special Needs Plan (SNP)
- [ ] Medicare Prescription Drug Plan (PDP)

Scope of Appointment documentation is subject to CMS record retention requirements

If applicable, provide the explanation why the SOA was not signed prior to meeting:

- [ ] Unplanned attendee
- [ ] Walk-in
- [ ] Beneficiary requested other health-related product information
- [ ] Other (please explain):

Product descriptions

Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP): A standalone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Other Health-Related Products
Medicare Supplement (Medigap) Products: Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and coinsurance amounts for Medicare approved services.

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

- (●) Tufts Health Plan Senior Care Options (HMO SNP) H8330-001-000
- ( ) Tufts Health Plan Senior Care Options CW (HMO SNP) H8330-002-000
- ( ) Tufts Health Plan Senior Care Options MassHealth Standard (Medicaid) Only*

*If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our Tufts Health Plan Senior Care Options program.

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 Tufts Health Plan Senior Care Options (HMO-SNP) service area, not be a resident of a chronic hospital, and not have any other comprehensive health insurance except Medicare, 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

1

First name M.I. Last name

_____

( ) Mr.
( ) Mrs.
( ) Ms.

Date of birth

_____

Sex

( ) M ( ) F

Preferred format for materials

( ) Braille ( ) Large print ( ) Audio cassette
( ) Other

Written language preferred

_____

Spoken language preferred

_____

2 Permanent address (where you live)

Street | City/town | State | Zip | Telephone number

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

Street | City/town | State | Zip | Telephone number

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

Name of nursing facility | Street | City/town | State | Zip | Telephone number

Medicare information

Please take out your Medicare card to complete this section.

- Please type your Medicare number, indicate your gender, and type the effective dates in the card shown on the right, so it matches 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.

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:

Tufts Health Plan Senior Care Options is a Medicare Advantage plan and has a contract with the federal government. Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options at any time. I will no longer be covered by Tufts Health Plan Senior Care Options on the first day of the month following the month I request to leave Tufts Health Plan Senior Care Options. (Example: I request to leave this plan on July 10; I am no longer covered by this plan on August 1.)

Tufts Health Plan Senior Care Options serves a specific service area. If I move out of that area that Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options, 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 Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options coverage begins, I must get all my health care from Tufts Health Plan Senior Care Options with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by Tufts Health Plan Senior Care Options and other services contained in my Tufts Health Plan Senior Care Options Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR TUFTS HEALTH PLAN SENIOR CARE OPTIONS 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 Tufts Health Plan Senior Care Options, he or she may be compensated based on my enrollment in Tufts Health Plan Senior Care Options.

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 Tufts Health Plan Senior Care Options 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 Tufts Health Plan Senior Care Options 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

Agent NPN _____ Agency Name _____

Name of staff member/agent/ broker (*if assisted in enrollment*) _____

Plan ID number _____

Effective date of coverage _____

- ☐ ICEP/IEP
- ☐ OEP
- ☐ AEP
- ☐ SEP—type: _____
- ☐ Not eligible

Notes

TUFTS Health Plan

Designated Representative Form

This form may be used to designate a representative to act on a member's behalf and authorize Tufts Health Plan* to disclose the member's protected health information to the representative.

All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

Member Information

For individual designating a representative to act on their behalf ("Member")

Name

ID number

Street address

City

State

Zip code

Birth date (MM/DD/YYYY)

Telephone number

Email address

Designated Representative Information

Member hereby authorizes Tufts Health Plan to disclose their information to the following individual and allow the individual to act on their behalf ("Designated Representative").

Name

Relationship to member

Street address

City

State

Zip code

Birth date (MM/DD/YYYY)

Telephone number

Email address

Terms of This Designation

1. Designated Representative is being appointed to act on Member's behalf with regard to certain matters related to their insurance coverage and benefits provided by Tufts Health Plan. This authority includes acting on Member's behalf to receive their health information from Tufts Health Plan and/or make changes related to enrollment, premium payments, benefits, claims, address changes, PCP changes, and/or requests for special communications.

2. Member's information disclosed by Tufts Health Plan may include, but is not limited to, demographic information, a history of illnesses and treatments, test results, and lists of allergies and medications. Member acknowledges that the disclosure may include information in the following protected categories: abortion, AIDS/ARC, alcohol and substance abuse (including information about services provided by federally assisted substance use disorder treatment programs), behavioral health, domestic violence, genetic testing, HIV, physical abuse, reproductive health, and sexually transmitted infection testing, treatment and prevention.

*For purposes of this Designation, Tufts Health Plan includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Harvard Pilgrim Group Health Plan, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., and Tufts Associated Health Plans, Inc., and all of their present and future affiliates. This Designation also applies to vendors acting on behalf of the above-named entities.

3. Tufts Health Plan is accepting this Designation and making associated disclosures for the purpose of fulfilling the request of Member.

4. Tufts Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on whether Member signs this Designation.

5. Tufts Health Plan will disclose Member's information in accordance with this Designation. Once the information is disclosed according to this Designation, it is no longer protected by HIPAA and may be redisclosed by the Designated Representative.

6. Member has a right to receive a copy of this Designation.

7. Unless indicated here, this Designation will remain in effect for two (2) years from the date of signature on this form (or, for a minor age 0–11, the day before the minor's 12th birthday, whichever is earlier). If Member desires an alternate end date, please specify a date here:

_____

8. Member may revoke this Designation in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Designation was in effect.

I have read and understand the terms of this Designation and I hereby authorize the disclosure of my information in the manner described above. I represent that the signature below is my own and that I am legally authorized to sign this document.

Signature of member or personal representative** _____ Date (MM/DD/YYYY) _____

Printed name _____ Relationship, if not member** _____

**This Designation will only be valid if signed by Member, the parent or guardian of Member if Member is age 0-11, or Member's Personal Representative (e.g., power of attorney, health care proxy, etc.). If you are not Member, please indicate your relationship to Member above and submit a copy of the applicable legal documentation if you are a Personal Representative (if not already provided).

Please return completed form and supporting legal documentation (if applicable) to:

Via fax: ATTN: Member Services Department
1-617-972-9405

Via mail: Tufts Health Plan Medicare Preferred
Member Services Department
PO Box 494
Canton, MA 02021-0494

If you have any questions about this form, please contact a Member Services representative at the number listed on the back of your Member ID card.

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-701-9000 (HMO) / 1-855-670-5934 (SCO) (TTY: 711).

MassHealth Permission to Share Information (PSI) Form

Commonwealth of
Massachusetts EOHHS
www.mass.gov/masshealth

Use this form if you want to give MassHealth permission to

- talk with another person or organization about your eligibility,
- share copies of your eligibility notices with them, or
- share copies of your records with another person or organization.

Complete all questions under Section 2 if you want to give MassHealth permission to talk with another person or organization about your eligibility and to share copies of your eligibility notices with them. (Do not complete Section 3 unless you are asking MassHealth to share written copies of your records.) This person or organization could be someone like:

- a family member, friend, or other trusted person,
- someone who helps take care of you,
- someone who helps you fill out MassHealth forms, or
- a social worker, lawyer, or health care advocacy group.

Complete all questions under Section 3 if you want to give MassHealth permission to share copies of your records with another person or organization. (Complete Section 3 only if you are asking MassHealth to share written copies of your records.) The information included in your records may include:

- MassHealth claims showing services you have received
- Past MassHealth applications and related information you've sent to us
- Past MassHealth notices that have been sent to you

Do not use this form if you want

- information about yourself,
- copies of your own records,
- information about your children under age 18 (You can usually get this without filling out any forms.),
- your eligibility and payment information to be shared with your health care provider. (Your health care provider can get information about your MassHealth eligibility and payment for services provided to you without you filling out any forms.), or
- to create an appeal representative status related to a Fair Hearing. (You should fill out the appropriate sections on the Fair Hearings Request (FHR-1) form OR complete a current Authorized Representative Designation (ARD) form. Current versions of both forms are available at www.mass.gov/service-details/masshealth-member-forms.)

Important: If you decide you want to fill out this form, you must fill out all applicable sections. Please print clearly and remember to **sign and date Section 7.** If a legal representative is completing this form, they must **sign and date Section 8.**

Section 1: Name of MassHealth applicant or member

I give permission for MassHealth and its representatives to share the information listed in Section 2 or Section 3 about:

Name of applicant or member whose information is to be shared*

Street*

City/State/Zip*

Date of birth*

Telephone number

MassHealth ID number*

Please Note: Fields with an asterisk * are required. If you do not have a MassHealth ID number, you can give us the last four digits of your social security number (SSN), if you have one.

Section 2: Permission for MassHealth to talk about your eligibility details and share copies of your eligibility notices

The person or organization that you write in Section 4 will be able to contact MassHealth to receive information described by the checked box below.

☑ **I give MassHealth permission to do the following:**

- talk about my eligibility details,
- talk about my MassHealth benefits, and
- share copies of eligibility notices with the person or organization written in Section 4.

Please note. These notices may contain financial information. Check this box only if you want the person or organization in Section 4 to be able to contact MassHealth to get eligibility information and get copies of your eligibility notices.
If you check this box, Masshealth will send copies of your eligibility notices to the person or organization in Section 4. They can also ask for copies of your eligibility notices. These notices have information about all members of a household. If you check this box, each member of your household who is 18 years or older will have to complete and sign a separate PSI form.

Do you also give MassHealth permission to share details about drug and alcohol treatment?

◯ **Yes.** MassHealth may share drug and alcohol treatment information.

◯ **No.** MassHealth may not share drug and alcohol treatment information.

Please Note. If you have given MassHealth permission to share your drug and alcohol treatment information for purposes of payment or health care operations activities, the recipient is permitted to further disclose your drug or alcohol treatment information to its contractors, subcontractors, or legal representatives to carry out payment or health care operations on its behalf.

Section 3: Permission for MassHealth to share written copies of your records

The person or organization written in Section 4 will receive copies of the records described by the checked box below.

- ☐ MassHealth claims showing services you have received from (month/year) _____ to (month/year) _____
- ☐ Past MassHealth applications and related information from (month/year) _____ to (month/year) _____
- ☐ Past MassHealth notices sent to you from (month/year) _____ to (month/year) _____
- ☐ Other (please be specific)

_____

Do you also give MassHealth permission to share drug and alcohol treatment information?

- ◯ **Yes.** MassHealth may share copies of drug and alcohol treatment information.
- ◯ **No.** MassHealth may not share copies of drug and alcohol treatment information.

Please Note: If you have given MassHealth permission to share your drug and alcohol treatment information for purposes of payment or health care operations activities, the recipient is permitted to further disclose your drug or alcohol treatment information to its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on its behalf.

Section 4: With whom do you want us to share information?

Write the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization. Fields with an asterisk * are required.

MassHealth may share the information listed in Section 2 or Section 3 with:

Name of person or organization: **Tufts Health Plan**

In care of *(name of person in organization to whom mail should be sent)*: **Attn: Enrollment Dept**

Street: **1 Wellness Way**

City/State/Zip: **Canton** **MA** **02021**

Telephone number: **800-890-6600**

Email: **SCO_Enrollment@Point32Health.org**

Section 5: Why do you want us to share your information?

Tell us why you want to share the information listed in Section 2 or Section 3. If you leave this section blank, we will assume you mean "at my request."

_____

Section 6: End of permission

This PSI will end in 12 months unless you specify an end date here.

12/31/2099

Section 7: Your signature

I understand the following:

- When the person or organization named in Section 4 gets this information from MassHealth, they may be able to share it with others without my permission. If they share that information, federal and state privacy laws may not protect the information.
- I need to send this PSI to the appropriate address in Section 9.
- I may cancel this permission at any time by sending a letter to:
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780
- If I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so.
- If I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in Section 4, my MassHealth benefits will not be affected in any way.
- In certain circumstances, MassHealth may not be able to share information.

Signature of applicant or member* | Name of applicant or member | Date

Fields with an asterisk * are required.

Section 8: Signature of Legal Representative

Fill out the following section if this form is being filled out by someone who has the legal authority to act on behalf of the applicant or member (such as the parent of a minor child, an authorized eligibility representative, or a legal guardian).

Signature of person filling out this form | Printed name of person filling out this form | Date

Address

Telephone number | Authority of person filling out this form to act on behalf of the applicant or member*

**If this form is being completed by someone who has legal authority to act on behalf of the applicant or member, such as a legal guardian appointed by a court or power of attorney, a copy of the applicable legal document must be attached.*

How do I submit this form?

Mail your form to:

MassHealth Enrollment Center
P.O. Box 4405
Taunton, MA 02780

Fax your form to: **(857) 323-8300**

If you have only checked off boxes in Section 3 to give MassHealth permission to share copies of your claims, application file, notices, or other records, then:

Email the PSI to privacy.officer@mass.gov

or mail it to:
MassHealth Privacy Office
One Ashburton Place, Room 1109
Boston, MA 02108

TUFTS Health Plan

Consent to Meet for Clinical Assessment

I agree to meet with a Tufts Health Plan Senior Care Options Care Manager within the first thirty (30) days of my enrollment in the Senior Care Options Plan. I hereby give my consent to participate in periodic clinical assessments with a Tufts Health Plan Senior Care Options Care Manager in which we will discuss my current and past health history and create, and update as needed, an Individualized Care Plan that will help me maximize my quality of life and live as independently as possible. I hereby authorize Tufts Health Plan to use my clinical assessment information for treatment, payment and health care operations, which may include releasing information to health care providers to coordinate and manage my care.

Signature	Print name	Date