Enrollment Handbook 03182021 v1

1.1 Cover Page

1.2 Introduction

Introduction

UnitedHealthcare® is pleased to provide a comprehensive enrollment handbook for all UnitedHealthcare Medicare Advantage and Part D branded plans:

- UnitedHealthcare
- AARP®
- Preferred Care Partners
- Medica HealthCare
- Erickson
- Rocky Mountain

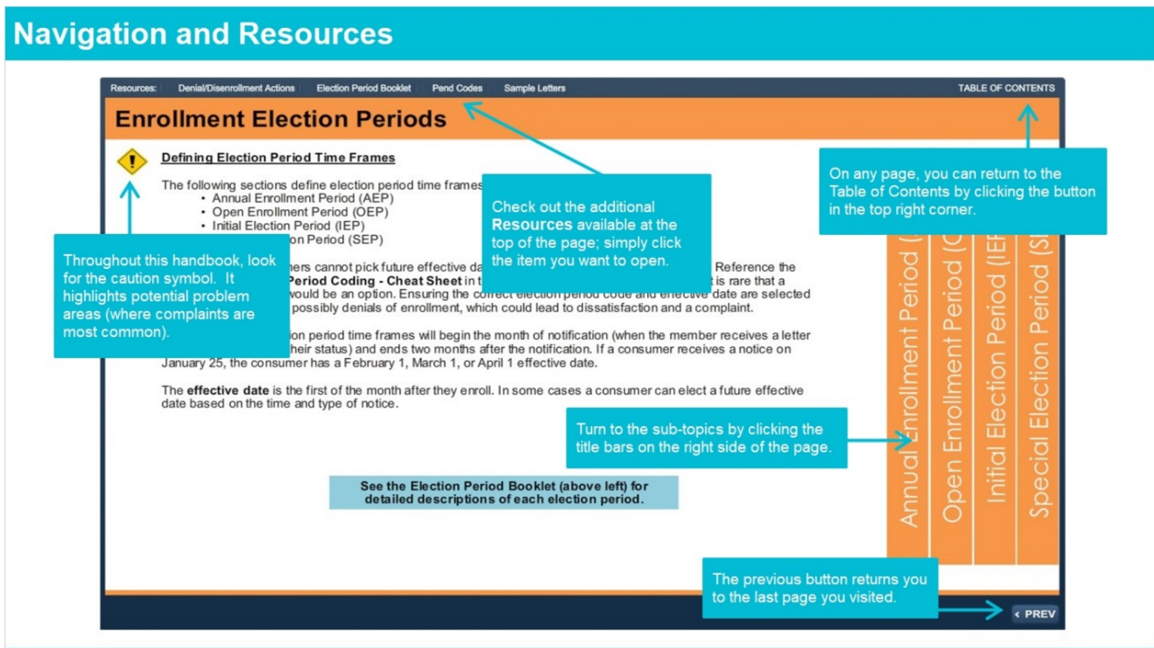
This handbook will help **improve paper application processing time, prevent errors, and enroll consumers more quickly**, and allow you to:

- Understand election periods including voluntary and involuntary member disenrollments
- Provide you with the exact election period Reason Code to insert on the application
- Walk you through how to complete a paper enrollment application from start to finish

Remember, using LEAN will prevent errors by not allowing submission if the information isn't complete. Any additional instructions for LEAN versus paper applications are noted throughout this handbook. Refer to LEAN training on **Learning Lab** for additional assistance with LEAN. (Jarvis\training\learning lab\content\LEAN)

1.3 Navigation and Resources

Navigation and Resources



1.4 Confidentiality Statement

Confidentiality Statement

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March 18, 2021

1.5 Main Menu / Table of Contents

Main Menu / Table of Contents

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- Enrollment Instructions
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- Paper Application Submission Guidelines
- Special Needs Plans Processing
- Denial/Cancel/Withdrawal/Disenrollment
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- Coordination of Benefits
- Premium and Billing
- Non-Payment of Premium
- Late Enrollment Penalty
- Out of Area
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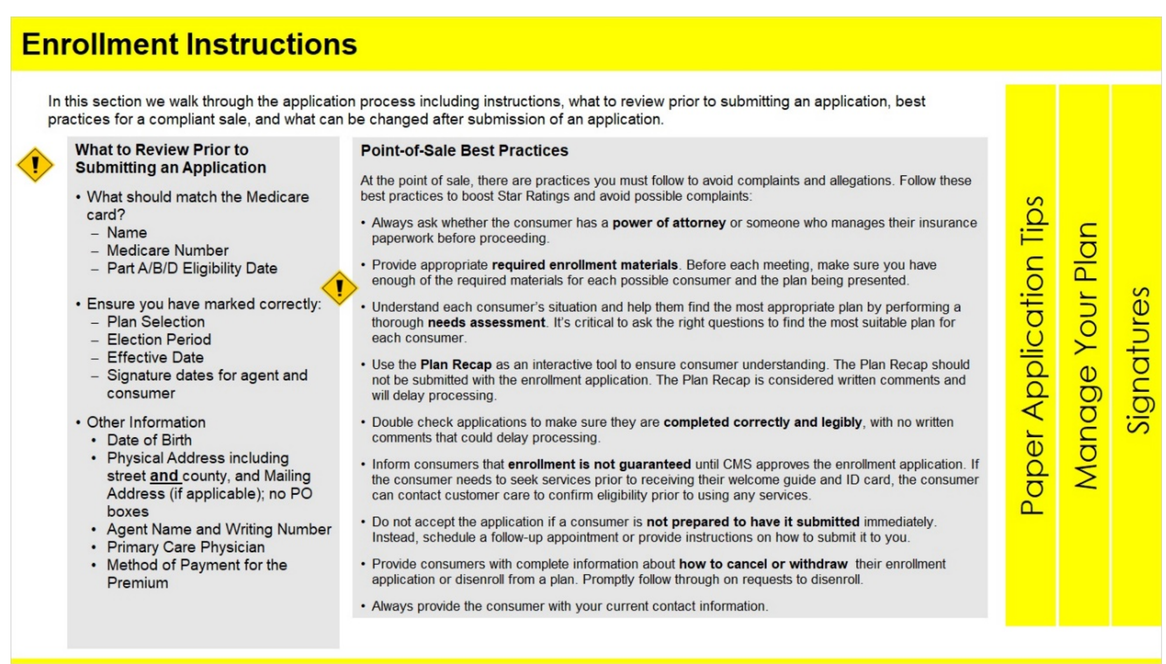
1.6 Enrollment Instructions



Tips (Slide Layer)

Paper Application Tips

Enrollment Instructions
Most paper applications are plan specific; **confirm that the application you are filling out is for the plan in which you intend to enroll the consumer.** The plan name and Contract ID are located at the top of the Enrollment Request Form. At the bottom of each page of the paper application there is a field for **enrollee name**. It is not required that you populate this field, however it is highly encouraged, in the event that pages would get separated. If the plan you are enrolling the consumer in has optional riders, you will need to fill in that section with the applicable rider selection. For those with a dental rider, you will see a reference to enter a dental facility number. This is not applicable for the Platinum dental rider. For all other dental riders, you can locate this number in the online provider directory.

Information About You Section
Although not every entry in this section is required for an application to flow through the application process, it is **strongly recommended** that you take the time to fill it in completely, legibly, and accurately.

- Names that do not match the Medicare card or SSA award letter will delay the application process. Likewise, an incorrect DOB (such as using the current year instead of the **birth year**) will delay the application process.
- Having the wrong address (P.O. boxes **cannot** be used for a permanent address) can result in a consumer/member missing important communications sent from UnitedHealthcare after enrollment. This can lead to member confusion, member dissatisfaction, and can lead to potential disenrollment. Verify the physical address against a piece of mail the consumer has on hand (but no PO boxes). Remind the consumer to notify UnitedHealthcare if they move.
- Valid phone numbers, as well as email addresses (if available) are critical as a means to contact the consumer/member. Email addresses are strongly encouraged as an alternative route of communication. Do not enter your email address in an email address field reserved for the consumer/member. UnitedHealthcare Enrollment actively reaches out to prospective consumers via phone when an application is missing information. The inclusion of as many valid phone numbers as are available will aid in the success of this outreach.

Information About Your Medicare Section
- Information in this section **must** match the Medicare card or SSA awards letter. Discrepancies in this section will cause the application to pend and possibly deny, which can lead to enrollment delays and customer dissatisfaction.
- In cases where the enrollee is new to Medicare, CMS' systems may not show eligibility yet. Attaching a copy of the Medicare Card or SSA Award Letter to the application will allow for proper processing with minimal delay.

How Do You Want to Pay Section
- If no selection is made in this section, the payment will default to a **monthly statement**
- Payment options are detailed in the Payment of Premium/Billing Options

Paper Application Tips | Manage Your Plan | Signatures

Manage (Slide Layer)

Manage Your Plan

- Understanding the consumer's preferred language will ensure they start their enrollment out right and receive materials in their preferred language, as well as any outreach that may be done
- Medicaid information is **required** for Dual SNP applications. Check Jarvis (Enrollment>Medicare & Medicaid Eligibility Lookup) or call the PHD to confirm if the consumer has the active Medicaid level necessary to be eligible for the DSNP.
- It is **important** to answer each question in this section for Coordination of Benefits (COB) purposes.
  - COB applies to consumers who are covered by more than one health care plan
  - COB helps avoid overpayment by either plan
  - If this information isn't correctly captured, claims information can be impacted and lead to customer dissatisfaction
- **Primary Care Physician (PCP)** information is required if requested on the enrollment application. Not filling it in, filling it in incorrectly or providing invalid information can lead to customer dissatisfaction. (Please see additional information in the Primary Care Physician Section regarding PCP auto assignment)
- Information about the dentist for plans offering dental coverage, important to populate if an option on the application, similar to PCP, however auto assignment will not occur
- **For Chronic SNP plans,** the Pre-Assessment and Chronic Condition Release of Information form are **required**, must be filled out, signed, and submitted with the application.

Paper Application Tips | Manage Your Plan | Signatures

Signatures (Slide Layer)

Signatures

Read and Sign

- It is important to go over the Statement of Understanding with the consumer to ensure understanding of the plan in which they are enrolling and any important information related to their enrollment and what they are signing, this can be used to check understanding along with the Plan Recap.
- It is **critical** the consumer or authorized representative sign the application or it **cannot** be processed. (LEAN will not let you submit an application without a signature.)
- Authorized representatives must fill out the authorized representative section of the application.
- Confirm the submission of each enrollment application you submit whether you are faxing or emailing a paper application or submitting an application via online or offline LEAN.

Licensed Sales Representatives

- Must sign and date/fill in the **initial receipt date** of the application immediately upon receipt
- Select a **valid** election period, you **must** enter the SEP reason if the election being used is not available for selection
- SEP eligibility date is **required** for those special election periods where a reason must be entered by the agent. If not entered, the enrollment **can/will** be denied

Paper Application Tips | Manage Your Plan | Signatures

1.7 Election Periods

Enrollment Election Periods

Defining Election Period Time Frames

The following sections define election period time frames and provide example:

- Annual Enrollment Period (AEP)
- Medicare Advantage Open Enrollment Period (MA OEP)
- Initial Election Period (IEP)
- Special Election Period (SEP)

In most cases, consumers cannot pick future effective dates, however there are a few exceptions. Reference the **Enrollment Election Period Coding - Cheat Sheet** in the Election Period Booklet (above left). It is rare that a retroactive enrollment would be an option. Ensuring the correct election period code and effective date are selected will prevent delays and possibly denials of enrollment, which could lead to dissatisfaction and a complaint.

In several cases, election period time frames will begin the month of notification (when the member receives a letter stating they are losing their status) and ends two months after the notification. If a consumer receives a notice on January 25, the consumer has a February 1, March 1, or April 1 effective date.

The **effective date** is the first of the month after they enroll. In some cases a consumer can elect a future effective date based on the time and type of notice. If multiple enrollment applications are received for the same consumer, regardless of the election period, the last application received by CMS is the one that will be used/enrolled.

When the results of a thorough needs analysis indicate more than one election period is available, and none of those election periods appear to be the **MOST** beneficial to use at this time, follow the election period hierarchy:

ICEP/IEP
MA OEP
SEP
AEP
OEPI

See the Election Period Booklet (above left) for detailed descriptions of each election period.

Annual Enrollment Period (AEP) | Medicare Advantage Open Enrollment Period (MA OEP) | Initial Election Period (IEP) | Special Election Period (SEP)

AEP (Slide Layer)

Annual Enrollment Period (AEP)

AEP runs from October 15 through December 7 every year. It is the election period that enables consumers to change or add Prescription Drug Plans (PDPs), change Medicare Advantage plans, return to Original Medicare, or enroll in a Medicare Advantage plan for the first time even if they did not enroll during their Initial Election Period.

All AEP enrollment elections become effective January 1 and disenrollments elections become effective December 31.

If more than one application is submitted for a consumer during AEP, the last application received is the one that will be valid.

Important! When Agents May Market for AEP

- Agents may not begin marketing until October 1.
- Agents may not accept or solicit submission of Enrollment Applications before October 15.
- If the Plan receives an unsolicited Enrollment Application (no agent information) prior to AEP, the Plan must retain the application and process the Enrollment Application beginning on the first day of the AEP with an application date of the same date.
- If th Plan receives an application prior to 10/15 with agent information on it, it will be denied for no election unless there is a valid SEP.
- The consumer will receive an acknowledgment letter when the Plan receives an early Enrollment Application.

Annual Enrollment Period (AEP)
Medicare Advantage Open Enrollment Period (MA OEP)
Initial Election Period (IEP)
Special Election Period (SEP)

MA OEP (Slide Layer)

Medicare Advantage Open Enrollment Period (MA OEP)

Annual Enrollment Period (AEP)

Members enrolled in an MA Plan may have an opportunity from January 1 through March 31 to switch MA plans (with or without drug coverage) or to disenroll from an MA plan and obtain coverage through Original Medicare (with or without a stand-alone PDP). *Use SEP(not MA OEP) for the PDP election period on the application.*

In addition, newly eligible MA individuals who enroll in an MA Plan can use the MA OEP, but only during the first three months after the start date of Part A and Part B. Use the MA OEP Newly Eligible election period on the application.

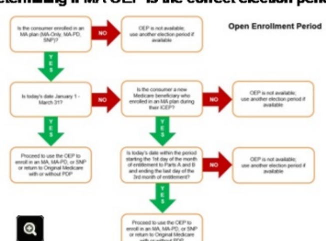
Members enrolled in stand-alone PDP plans are not eligible for the Open Enrollment Period election because the MA OEP is only available to those enrolled in an MA plan.

If more than one application is submitted for a consumer during MA OEP, the last application received prior to the first effective date is the one that will be valid.

Note: *Agents are not permitted to do any targeted marketing to any carrier's (UnitedHealthcare or another) MA/MA-PD members to entice or encourage them to use the MA OEP election code to make a plan change.*

Use the flow chart below for help in determining if MA OEP is the correct election period.

Click the magnifying glass to enlarge the images. Click again to exit the enlargement.



Medicare Advantage Open Enrollment Period (MA OEP)
Initial Election Period (IEP)
Special Election Period (SEP)

IEP (Slide Layer)

Initial Election Period (IEP) / Initial Coverage Election Period (ICEP)

Annual Enrollment Period (AEP)

Medicare Advantage Open Enrollment Period (MA OEP)

The period allowing consumers newly eligible for Medicare to make an initial election to enroll in a Medicare Advantage Plan or Prescription Drug Plan. ICEP is for consumers newly eligible for Medicare Parts A and B who elect an MA-only Plan. IEP is for consumers newly eligible for Medicare Parts A and B who elect a stand-alone PDP or MA-PD Plan.

For Medicare Advantage and Prescription Drug Plans, a consumer has a 7-month enrollment period that includes the three months prior to their month of eligibility, the month they become eligible, and the three months following the month of eligibility.

A member's plan effective date will be:
- 1st day of month of Medicare eligibility (Part B is active), if the enrollment application is received prior to that date (often the month of the consumer's 65th birthday).
- 1st day of month following receipt of the enrollment application, if the enrollment application is received in last four months of the IEP/ICEP.

Initial Election Period (IEP)

Special Election Period (SEP)

SEP (Slide Layer)

Special Election Period (SEP)

Annual Enrollment Period (AEP)

Medicare Advantage Open Enrollment Period (MA OEP)

Initial Election Period (IEP)

A SEP allows consumers to make an election change in accordance with applicable requirements anytime during the year, including during the period outside of IEP, AEP or MA OEP. There are various types of SEPs, including SEPs for dual eligibles, and for individuals whose current plan terminates, who change residence and who meet "exceptional conditions" as CMS may provide.

Depending on the nature of the particular special election period, an individual may*:
- Disenroll from an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

The SEP for the individual ends when the individual elects a new plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.

**These are only some examples of actions a consumer may elect based on the SEP. The type of plan in which the consumer/member can enroll will depend on the particular SEP.*

Special Election Period (SEP)

1.8 SEP – Dual/LIS Maintaining Limitations

SEP – Dual/LIS Maintaining Limitations

The Centers for Medicare and Medicaid Services (CMS) has established limitations on the use of the Dual LIS SEP. Dual-eligible or LIS-eligible consumers who are maintaining their status have a quarterly (not monthly) opportunity to change plans within the first nine months of the calendar year. The change cannot be made during calendar quarter four; eligible consumers in quarter four would use AEP or other SEP.

To help determine if a consumer can use the Dual LIS Maintaining election period, review the flow chart on the right. Notice that **you should check Jarvis (Enrollment>Medicare & Medicaid Eligibility Lookup) or call the PHD** to confirm:

- If the consumer has already used Dual LIS maintaining this calendar quarter <u>and</u>
- If the consumer has been identified as "at risk" or "potentially at risk" under the Comprehensive Addiction and Recovery Act (CARA). These consumers are referred to as in CARA status.

After verifying DSNP eligibility, you will need to determine if the enrollee is eligible for a DNSP SEP (in addition to the two items stated above).

Click the page tabs on the right to read more about CARA and the exception for Medicare-Medicaid Plans (MMP).

PHD: 888-381-8581
7:00 a.m. – 9:00 p.m. CT
Monday – Friday

Special Election Period for Dual/LIS Consumers

Is it October 1 – December 31?* — YES → SEP-Dual/LIS Maintaining is not available; use AEP or another election period if available

NO ↓

Does the consumer have any other election period other than SEP-Dual/LIS Maintaining available to them? — YES → Use the other available election period

NO ↓

Has the consumer used the Dual/LIS Maintaining SEP this calendar quarter as evidenced by the application signature date)? Call PHD to confirm — YES → SEP-Dual/LIS Maintaining is not available; use another election period if available

NO ↓

Has the MA-PD plan identified the consumer as "potential at-risk" or "at-risk" and sent written notice to the consumer? Call PHD to confirm — YES → SEP-Dual/LIS Maintaining is not available while the "potential at-risk" or "at-risk" designator is in place; use another election period if available

NO ↓

Proceed to use SEP-Dual/LIS Maintaining

CARA | MMP Waiver

CARA (Slide Layer)

Comprehensive Addiction and Recovery Act (CARA)

*Source: CMS.gov/session5_CARA_Opioids_2018_Spring.pdf

As required by CARA, Part D plan sponsors may voluntarily adopt drug management programs for consumers who are at risk of misusing or abusing frequently abused drugs. If a consumer is identified by the Part D plan sponsor as "at risk" or "potentially at risk," the consumer is not allowed to use the Dual/LIS Maintaining SEP. The risks are defined as:

> **At risk**– a Part D eligible individual who is identified by current Part D plan sponsor as not an exempt consumer and determined to be at-risk for misuse or abuse of such frequently abused drugs.
>
> **Potential at risk**– a Part D eligible individual with respect to whom a Part D plan sponsor receives a notice upon the consumer's enrollment in such plan that the consumer was identified as not an exempt consumer and determined to be at-risk for misuse or abuse of such frequently abused drugs.

The minimum criteria* for risk is:

- **≥ 90 morphine milligram equivalent (MME) AND either**
- **3+ opioid prescribers AND 3+ opioid dispensing pharmacies OR**
- **5+ opioid prescribers AND 1+ opioid dispensing pharmacies**

Limitation begins as of the date on the initial notice provided to the "potential at-risk". The chart below outlines when the limitation ends:

Situation	SEP Limitation Ends
Plan decides not to identify the "potential at-risk" consumer as an "at-risk" consumer.	60 days from the date on the initial notice, or the date the consumer receives notice of the plan's decision, if earlier.
The "at-risk" or "potential at-risk" consumer identification is subsequently removed by the plan or through consumer's favorable appeal of an "at-risk" determination.	The date that the designation is removed by the plan or upon effectuation of a favorable appeal.
The plan determines the consumer is "at-risk".	12 months from the date the individual is determined to be "at-risk".
The plan extends the "at-risk" designation beyond the initial 12 months.	24 months from the date the individual is determined to be "at-risk".

CARA | MMP Waiver

MMP Waiver (Slide Layer)

MMP Waiver

CARA

MMP Exception to The Quarterly Requirement:

A consumer in an MMP can enroll, change or disenroll at any time during the year. The states with MMPs are:

CA, IL, MA, MI, NY, OH, RI, SC, and TX

You should call the PHD to confirm if they have been identified as in CARA status.

This waiver does not extend to consumers whose current Part D plans placed them in a CARA status.

For example, if a full-benefit dual eligible consumer requests to enroll in our MA plan and has no available enrollment periods, you should check if they are enrolled in an MMP and confirm they are not in a CARA status. If they are in an MMP and have no CARA status, they may disenroll from the MMP by enrolling in our MA plan any time during the year.

Note: UnitedHealthcare only offers MMPs in OH and TX. See the Agent Guide, Marketing in a State with a Medicare-Medicaid Plan (MMP), for more details.

PHD: 888-381-8581
7:00 a.m. – 9:00 p.m. CT
Monday – Friday

For MMP HPBP codes, see the resource above.

MMP Waiver

1.9 Primary Care Physician

Primary Care Physician

The importance of a Primary Care Provider

Discussions regarding a PCP should occur at the point of sale to set expectations and ensure the consumer has a provider to coordinate their care. If the consumer does not have a PCP or does not have a PCP in the plan's network, they must select one from the plan's provider network. Agents may assist the consumer in selecting a PCP, but should not refer a consumer to a particular provider or medical group.

PCPs play an important role in helping members:
- Make smart, healthy lifestyle choices
- Manage prescription drugs and make sure they work well together
- Manage specialist care and help avoid extra costs and unnecessary tests
- Understand the health care system

PCP ID numbers can be found in the provider search tool and should be recorded on the enrollment application (paper or LEAN):
- Provider search tool located under the "Enrollment" tab "Provider and Rx Search" section of ***Jarvis***
- Valid PCP IDs must be copied onto the application exactly as displayed
- PHD support is available if online tool is not accessible

Four different ways that PCP ID numbers are processed:
- **Valid** - In network PCP with a correct PCP ID
- **Missing** - No PCP information is listed on the application
- **Invalid** - Out-of-network PCP name or ID
- **Incorrect** - Either the PCP name or ID for an in-network PCP was entered incorrectly on the application

Best Practices to Avoid PCP Auto-Assignment:
- Use the **online provider search tool** because it is the most up-to-date. The online provider search tool is on ***Jarvis***. Do not use any other online directory.
- If you cannot access the tool when meeting with a consumer, contact the PHD or download a copy from the Sales Material Portal in ***Jarvis*** prior to your meeting. Be sure to check for an updated version every month if using the downloaded version.
- Printed provider directories are a **higher risk** for outdated/inaccurate information.
- Confirm the provider is in-network and accepting UnitedHealthcare membership for the plan in which the consumer is enrolling. A provider can be in-network for one plan, multiple plans, or all plans in a market.
- Copy the provider ID and name **exactly** as it appears in the online directory. Please **do not add or omit digits**.

PCP Auto-Assignment Process

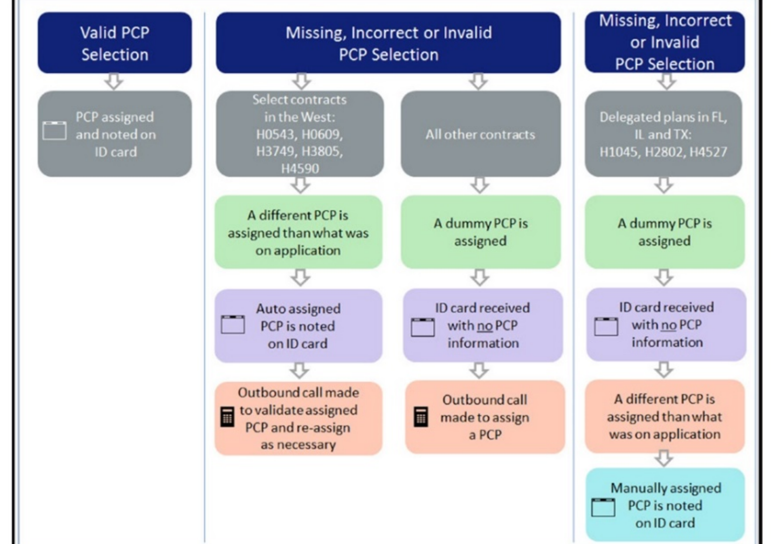
HMO and PPO Plans

Physician Status (Online)

Physician Status (Printed)

PCP Auto-Assign (Slide Layer)

PCP Auto-Assignment Process



PCP Auto-Assignment Process
HMO and PPO Plans
Physician Status (Online)
Physician Status (Printed)

HMO and PPO Plans (Slide Layer)

HMO and PPO Plan Guidelines (Paper or LEAN)

HMO Plans

- The PCP has to be in-network.

PPO Plans

If the PCP is out-of-network (NonPar)

- In the Provider Name section, the agent should write or type the actual PCP name
- In the PCP Number section, the agent should write or type **NonPar Prov** (has to be exact wording and spacing in LEAN)

If the consumer refuses PCP

- In both the Provider Name and Number sections, write or type **Refused PCP** (has to be exact wording and spaces in LEAN)

If the consumer is undecided

- In both the Provider Name and Number sections, write or type **Not Decided** (has to be exact wording and spacing in LEAN)

HMO and PPO Plans
Physician Status (Online)
Physician Status (Printed)

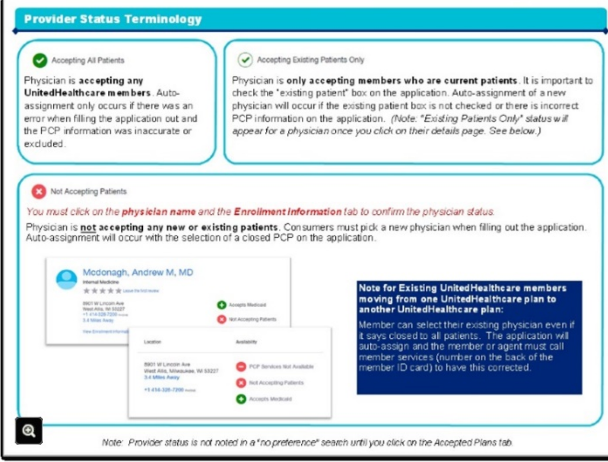
Physician Status (Online) (Slide Layer)

Understanding Physician Status in the Online Provider Directory

PCP Auto-Assignment Process

HMO and PPO Plans

Look up every consumer's Primary Care Physician in the online provider directory to determine network status and the PCP's Physician Status. There are three statuses, and it is important that you understand what each status means to the consumer you are enrolling. Also be certain the provider is in network for the plan in which you are enrolling the consumer. (Find complete instructions in the Provider Search User Guide on Jarvis/Knowledge Center/Systems & Technology.)



Physician Status (Online)

Physician Status (Printed)

Physician Status (Printed) (Slide Layer)

Physician Status in the Printed Directory

PCP Auto-Assignment Process

HMO and PPO Plans

Physician Status (Online)

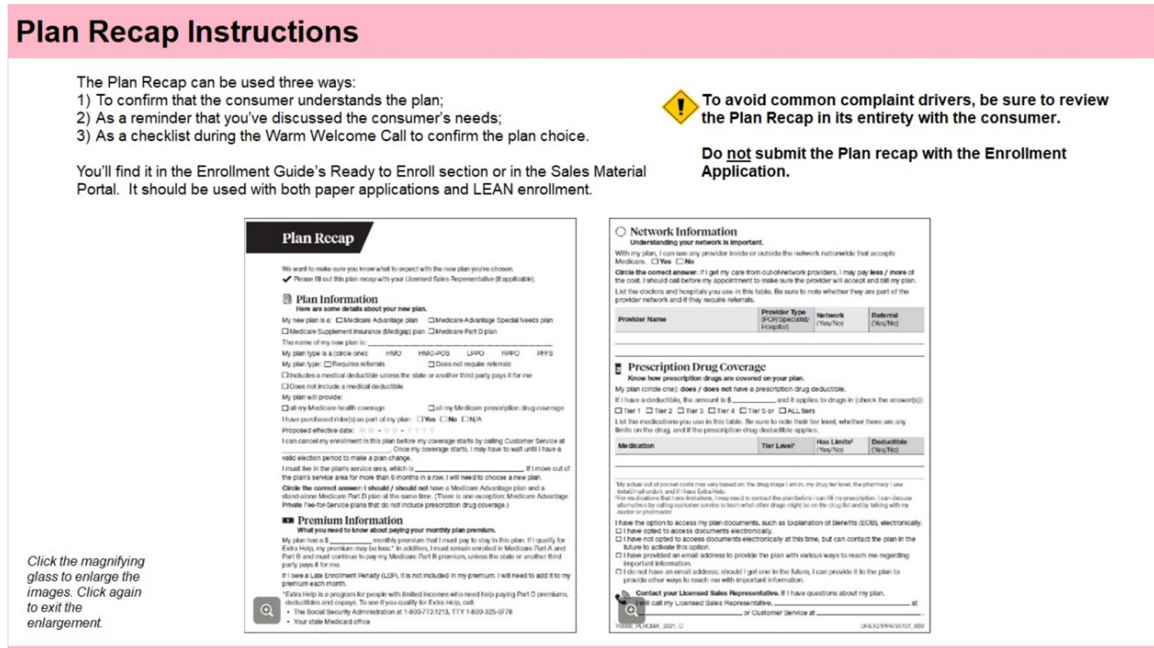
UnitedHealthcare strongly recommends using the online provider search tool or the PHD when looking up providers. The online directory is updated daily. There is a printed directory available via the Sales Material Portal, but you need to use caution when using this as it is only updated monthly. The physician status is noted with numbers next to the provider's name and the meaning in a legend at the bottom of each page (see image below).

[1] Closed to new enrollment. [2] Accepting existing patients only. [3] Board Certified.

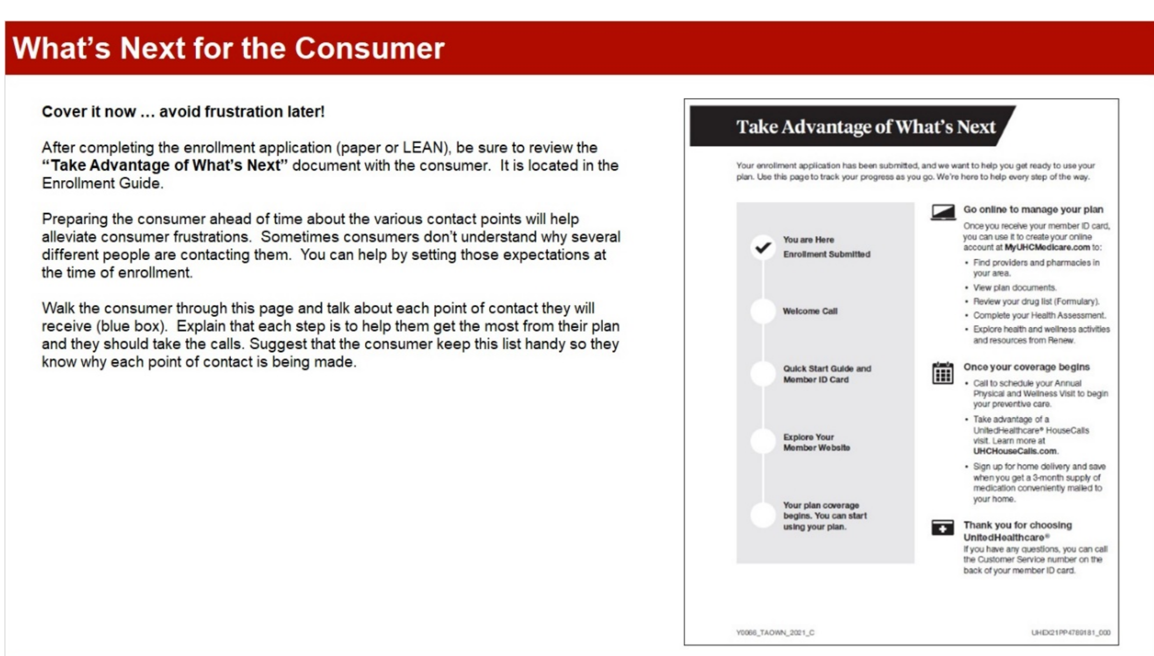
Please call the provider's office to confirm the provider's enrollment availability. For more information about mental health benefits, see, "Accessing your mental health benefits" in the Introduction section of this directory.

Physician Status (Printed)

1.10 Plan Recap Instructions



1.11 What's Next for the Consumer



1.12 Paper Application Samples

Paper Application Sample

Page 1 of 9

AARP | Medicare Advantage from UnitedHealthcare

2021 Enrollment Request Form

Please contact the plan if you need this information in another language or an accessible format (Braille).

☐ **AARP Medicare Advantage Plan 1 (HMO) H0432-001-000 - H1**

This is a Health Maintenance Organization (HMO) plan. It has a network of doctors, specialists, hospitals and other providers you must use.

Select optional supplemental benefits in addition to what is included with your plan.

You can add the following benefit rider(s) for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. If more than one Dental Rider is listed, please select only one. See the Summary of Benefits for more information, including costs.

☐ **Platinum Dental Rider**

Information about you. (Please type or print in black or blue ink)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date MM - DD - YYYY	Sex ☐ Male ☐ Female
Daytime Phone Number ( ) -	Mobile Phone Number ( ) -

Permanent Residence Street Address **(P.O. Box is not allowed)**

City	County	State	ZIP Code

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	County	State	ZIP Code

Email Address

Enrollee Name

Agent Name / ID No.

Y0066_ERFMA1_2021_M AAAL21HM4751469_000

This section contains a sample Medicare Advantage (MA) paper enrollment application (officially called Enrollment Request Form) with call outs to guide you through specific sections of the form.

The form for 2021 is structured differently. There are fields that are required by CMS and there are fields that UnitedHealthcare would like completed. **Please do your best to complete the entire application**.

On each page, **hover over the "i" (information) icon to review the guidance.**

Pages 1 and 2

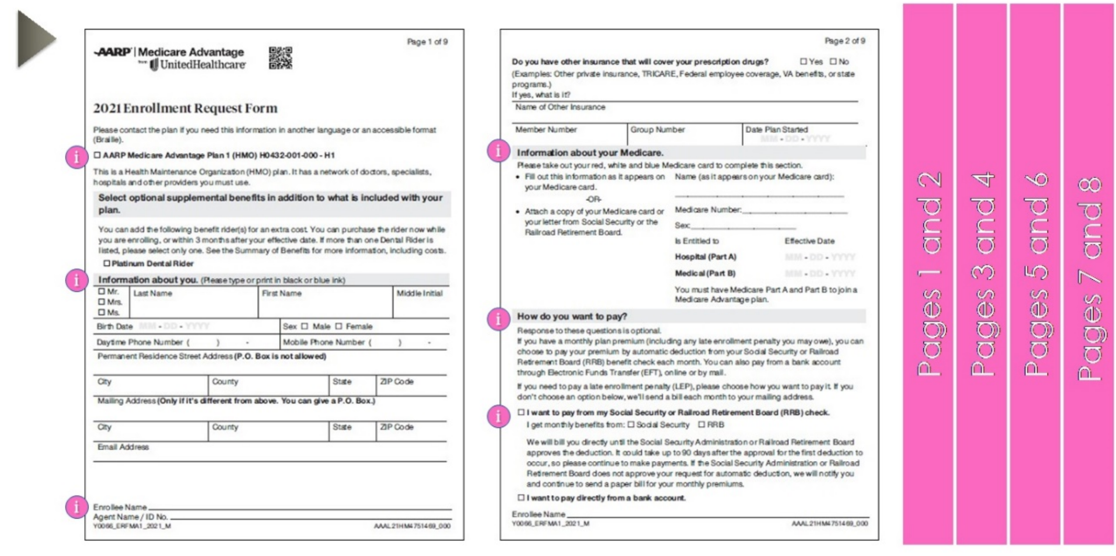
Pages 3 and 4

Pages 5 and 6

Pages 7 and 8

1 and 2 (Slide Layer)

Paper Application Pages 1 and 2



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AARP | Medicare Advantage from UnitedHealthcare

2021 Enrollment Request Form

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This is a Health Maintenance Organization (HMO) plan. It has a network of doctors, specialists, hospitals and other providers you must use.

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You can add the following benefit rider(s) for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. If more than one Dental Rider is listed, please select only one. See the Summary of Benefits for more information, including costs.

☐ **Platinum Dental Rider**

Information about you. (Please type or print in black or blue ink)

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date MM - DD - YYYY	Sex ☐ Male ☐ Female
Daytime Phone Number ( ) -	Mobile Phone Number ( ) -

Permanent Residence Street Address **(P.O. Box is not allowed)**

City	County	State	ZIP Code

Mailing Address **(Only if it's different from above. You can give a P.O. Box.)**

City	County	State	ZIP Code

Email Address

Enrollee Name

Agent Name / ID No.

Y0066_ERFMA1_2021_M AAAL21HM4751469_000

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Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, Federal employee coverage, VA benefits, or state programs.)

If yes, what is it?

Name of Other Insurance

Member Number	Group Number	Date Plan Started MM - DD - YYYY

Information about your Medicare.

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 Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Sex:

Is Entitled to	Effective Date
Hospital (Part A)	MM - DD - YYYY
Medical (Part B)	MM - DD - YYYY

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

How do you want to pay?

Response to these questions is optional.

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT), online or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it. If you don't choose an option below, we'll send a bill each month to your mailing address.

☐ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

We will bill you directly until the Social Security Administration or Railroad Retirement Board approves the deduction. It could take up to 90 days after the approval for the first deduction to occur, so please continue to make payments. If the Social Security Administration or Railroad Retirement Board does not approve your request for automatic deduction, we will notify you and continue to send a paper bill for your monthly premiums.

☐ **I want to pay directly from a bank account.**

Enrollee Name

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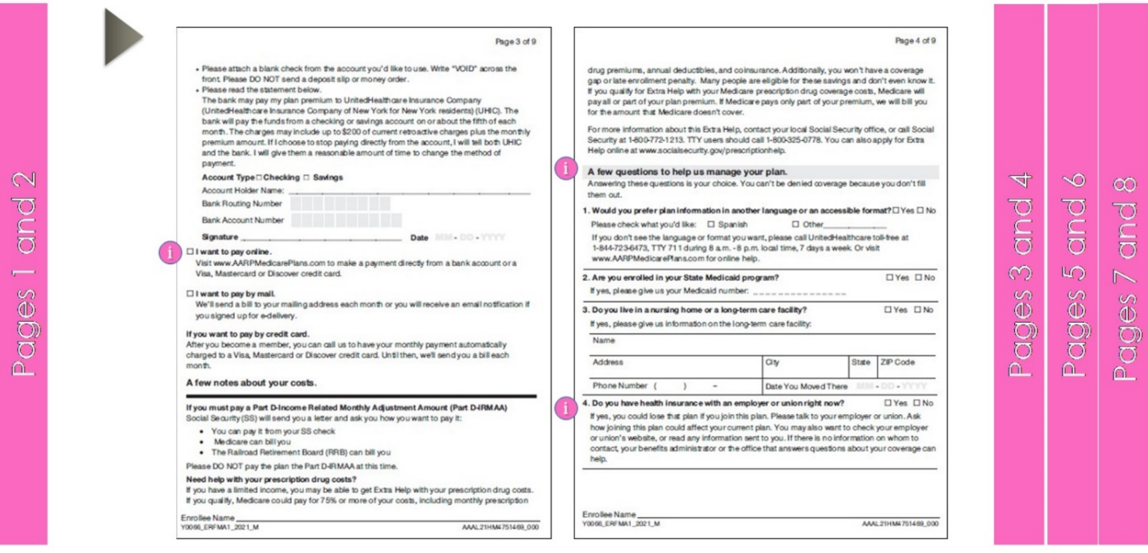
3 and 4 (Slide Layer)



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- Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.
  The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name: ____________

Bank Routing Number

Bank Account Number

Signature ____________ **Date** MM - DD - YYYY

☐ **I want to pay online.**
Visit www.AARPMedicarePlans.com to make a payment directly from a bank account or a Visa, Mastercard or Discover credit card.

☐ **I want to pay by mail.**
We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

If you want to pay by credit card.
After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

A few notes about your costs.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)
Social Security (SS) will send you a letter and ask you how you want to pay it:

- You can pay it from your SS check
- Medicare can bill you
- The Railroad Retirement Board (RRB) can bill you

Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription

Enrollee Name ____________
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drug premiums, annual deductibles, and coinsurance. Additionally, you won't have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don't even know it. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn't cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

A few questions to help us manage your plan.
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

1. Would you prefer plan information in another language or an accessible format? ☐ Yes ☐ No
Please check what you'd like: ☐ Spanish ☐ Other ____________
If you don't see the language or format you want, please call UnitedHealthcare toll-free at 1-844-723-6473, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.AARPMedicarePlans.com for online help.

2. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes, please give us your Medicaid number: ____________

3. Do you live in a nursing home or a long-term care facility? ☐ Yes ☐ No
If yes, please give us information on the long-term care facility:

Name			
Address	City	State	ZIP Code
Phone Number ( ) -	Date You Moved There MM - DD - YYYY		

4. Do you have health insurance with an employer or union right now? ☐ Yes ☐ No
If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union's website, or read any information sent to you. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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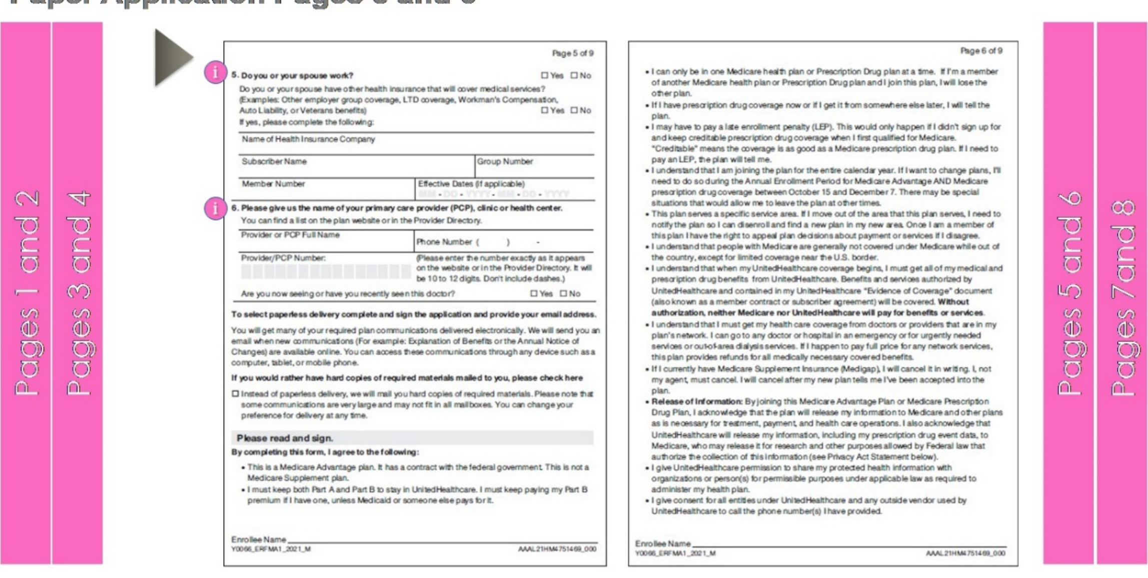
5 and 6 (Slide Layer)



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5. Do you or your spouse work? ☐ Yes ☐ No
Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman's Compensation, Auto Liability, or Veterans benefits) ☐ Yes ☐ No
If yes, please complete the following:

Name of Health Insurance Company	
Subscriber Name	Group Number
Member Number	Effective Dates (if applicable) MM - DD - YYYY - MM - DD - YYYY

6. Please give us the name of your primary care provider (PCP), clinic or health center.
You can find a list on the plan website or in the Provider Directory.

Provider or PCP Full Name	Phone Number ( ) -
Provider/PCP Number:	(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No

To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Please read and sign.
By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I must keep both Part A and Part B to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.

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- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay an LEP, the plan will tell me.
- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Annual Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan serves a specific service area. If I move out of the area that this plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this plan I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor UnitedHealthcare will pay for benefits or services**.
- I understand that I must get my health care coverage from doctors or providers that are in my plan's network. I can go to any doctor or hospital in an emergency or for urgently needed services or out-of-area dialysis services. If I happen to pay full price for any network services, this plan provides refunds for all medically necessary covered benefits.
- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- **Release of Information:** By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that UnitedHealthcare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- I give consent for all entities under UnitedHealthcare and any outside vendor used by UnitedHealthcare to call the phone number(s) I have provided.

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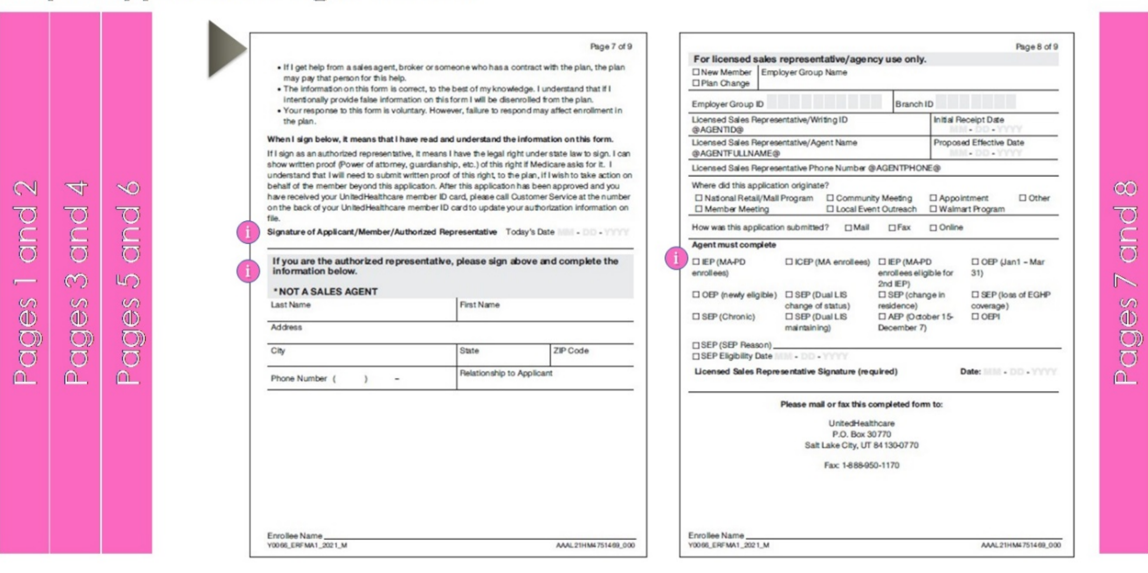
7 and 8 (Slide Layer)

Paper Application Pages 7 and 8



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- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- 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 will be disenrolled from the plan.
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

When I sign below, it means that I have read and understand the information on this form.

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature of Applicant/Member/Authorized Representative Today's Date MM - DD - YYYY

If you are the authorized representative, please sign above and complete the information below.

***NOT A SALES AGENT**

Last Name	First Name	
Address		
City	State	ZIP Code
Phone Number ( ) -	Relationship to Applicant	

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For licensed sales representative/agency use only.

☐ New Member ☐ Plan Change | Employer Group Name

Employer Group ID | Branch ID

Licensed Sales Representative/Writing ID @AGENTID@ | Initial Receipt Date MM - DD - YYYY

Licensed Sales Representative/Agent Name @AGENTFULLNAME@ | Proposed Effective Date MM - DD - YYYY

Licensed Sales Representative Phone Number @AGENTPHONE@

Where did this application originate?
☐ National Retail/Mall Program ☐ Community Meeting ☐ Appointment ☐ Other
☐ Member Meeting ☐ Local Event Outreach ☐ Walmart Program

How was this application submitted? ☐ Mail ☐ Fax ☐ Online

Agent must complete

☐ IEP (MA-PD enrollees) ☐ ICEP (MA enrollees) ☐ IEP (MA-PD enrollees eligible for 2nd IEP) ☐ OEP (Jan1 – Mar 31)
☐ OEP (newly eligible) ☐ SEP (Dual LIS change of status) ☐ SEP (change in residence) ☐ SEP (loss of EGHP coverage)
☐ SEP (Chronic) ☐ SEP (Dual LIS maintaining) ☐ AEP (October 15-December 7) ☐ OEPI

☐ SEP (SEP Reason) ______
☐ SEP Eligibility Date MM - DD - YYYY

Licensed Sales Representative Signature (required) **Date:** MM - DD - YYYY

Please mail or fax this completed form to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170

Enrollee Name ______
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1.13 Paper Application Submission

Paper Application Submission

Check with your manager or up line for preferred enrollment application submission method based on a specific plan. If advised to send paper applications directly to UnitedHealthcare, refer to the information below and send the application to the appropriate enrollment center, based on plan type. Use the "Preferred Submission Method" column whenever possible.

Submit enrollment applications within 24 hours of receipt. Do not submit Scope of Appointment (SOA) forms to UnitedHealthcare or Peoples Health. Refer to the Scope of Appointment Job Aid on Jarvis for SOA retention requirements.

Enrollment applications contain Protected Health Information (PHI) and Personally Identifiable Information (PII). Agents must follow the submission instructions contained within this document to ensure PHI/PII is protected. Failure to follow instructions may result in corrective and/or disciplinary action.

Click the magnifying glass to enlarge the images. Click again to exit the enlargement.

Product Type and Brand	Preferred Submission Method	Non-Preferred Submission Method
Medicare Advantage (including SNPs) and Prescription Drug Plans Includes these brands: AARP, Care Improvement Plus, Medica Health Care Plans, Preferred Care Partners, Rocky Mountain Health Plan, Senior Dimensions, Sierra Spectrum Plan, Symphonix, and UnitedHealthcare	Secure* Email: MandRenrollment@uhc.com OR Fax[1] **1-888-950-1170** (all PDP and non-restricted MA Plan contracts only) OR Fax[1] **1-888-950-1169** (restricted MA Plan contracts only)	**Overnight**[2] delivery: UHC M&R B&E 4050 South 500 West, Suite 50 Salt Lake City, UT 84123
UnitedHealthcare Senior Care Options Medicare Advantage Plan	**Fax[1] 1-855-250-2168**	**Overnight**[2] delivery: UnitedHealthcare 950 Winter Street Suite 3800 Waltham, MA 02451
Peoples Health Medicare Advantage (including SNPs) Plans	Fax[1] **1-504-849-6958** or **1-866-301-8858**	**Overnight**[2] delivery: Peoples Health Attn: Sales & Membership Operations 3838 N. Causeway Blvd. Suite 2200 Metairie, LA 70002
AARP® Medicare Supplement Insurance Plan	**Standard** delivery: UnitedHealthcare Insurance Company Enrollment Division P.O. Box 105331 Atlanta, GA 30348-5331 **Overnight**[2] delivery (must arrive by 9am): UnitedHealthcare Insurance Company Enrollment Division 4868 GA Highway 85, Suite 100 Forest Park, GA 30297	Fax[1] **1-888-836-3985**

* Refer to secure email instructions
[1] Refer to fax instructions
[2]Agents are responsible for covering the cost of overnight delivery service

Emailing a Paper Application

Faxing a Paper Application

Emailing (Slide Layer)

How to Email a Paper Application to UnitedHealthcare

Secure Email

All Medicare Advantage (MA) Plan (including Special Needs Plans (SNP) and stand-alone Prescription Drug Plan (PDP) paper enrollment applications may be emailed to MandRenrollment@uhc.com. Follow these instructions to email in an MA Plan or PDP enrollment application:

1. Convert each MA Plan or PDP enrollment application to a separate, non-editable PDF (no greater than 15 MB). Do not scan/convert multiple applications into a single PDF.
2. Attach PDF to an email (email must not exceed 15 MB).
3. Send using **UnitedHealthcare's secure email** to MandRenrollment@uhc.com <mailto:MandRenrollment@uhc.com>.
   You must use UnitedHealthcare's secure email. Failure to do so may result in corrective and/or disciplinary action. Note: If you do not have access to UnitedHealthcare's secure email, send a request for access to UnitedHealthcare's secure email to PHD@uhc.com <mailto:PHD@uhc.com> . Do not send the application to the PHD with the request. The PHD will send to you a secure email in return, which will enable you to access and register to use UnitedHealthcare's secure email service. **Smart Tip:** Bookmark UnitedHealthcare's secure email service so you can easily access it.
4. After emailing an application, you will immediately receive an email from MandRenrollment@uhc.com <mailto:MandRenrollment@uhc.com> that confirms your email was delivered.
5. **Expect a confirmation email** (1-4 hours) with a listing of the file(s) received for processing. Note: While all files received will be listed, only those with a ".pdf"" extension will be processed. All others must be re-submitted as ".pdf".

Emailing a Paper Application

Faxing a Paper Application

Faxing (Slide Layer)

How to Fax a Paper Application to UnitedHealthcare

Emailing a Paper Application

Fax

Follow these instructions to fax in an enrollment application:

1. A fax cover page is required when submitting any MA Plan, PDP, or Medicare Supplement enrollment application. You may use any fax cover page provided it contains the following statement in its entirety:

   CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

2. For MA Plans only, carefully select the correct fax number based on the MA Plan contract number (H-PBP).
   - **Non-Restricted MA Plan Contracts and all PDP: 1-888-950-1170**
     Use this number for any contract not listed below in the restricted contracts section.
   - **Restricted MA Plan Contracts: 1-888-950-1169**

State	Contract	State	Contract	State	Contract
AZ:	H0321-002	GA:	H2228-044	TX:	H2228-041
	H0321-004		H5322-030		H4514-001
	H5008-012		R2604-004		H4527-003
					H4527-004
FL:	H1045-012	NJ:	H3113-005		H4527-006
	H1045-038				H4527-015
	H1045-039	TN:	H0251-002		H4590-020
	H1045-053		H0251-004		H4590-022
	H1889-002		H0251-005		H4590-033
	H5420-006				H5322-025
	R0759-003				H5322-026
					R6801-011

Faxing a Paper Application

1.14 SNP Processing Differences

SNP Processing Differences

Below is defined distinction for SNP Processing based on Business Entity.

Plan Type	Business Entity	
	UnitedHealthcare Branded	Preferred Care Partners
Chronic SNP	Post-Verification	Post-Verification
Dual SNP	Pre-Verification	Pre-Verification

Pre-Enrollment Verification Process for Dual Eligibility for UnitedHealthcare Branded Plans

Dual SNP Verification At the Point-of-Sale

- **Paper**: Agents must submit to the applicable enrollment center. Refer to the paper application submission guide for the applicable enrollment center (see the 2021 paper application submission methods section).
- **Electronic**: All dual eligible plans will be available through LEAN for 2021 online. (Peoples Health and Rocky Mountain do not use LEAN.)

Pre-Verification Process for Dual SNP

- UnitedHealthcare verifies dual eligibility through the applicable state website.
- UnitedHealthcare must verify eligibility within 21 days of receipt of the application or until the end of the month (whichever is later).
- If verification cannot be done via the state website, a letter is sent to the member requesting proof of eligibility.
- If UnitedHealthcare cannot verify dual eligibility within 21 days of receipt of the application or the end of the month (whichever is later), a denial of enrollment letter will be sent.

Dual SNP Verification Agent Involvement

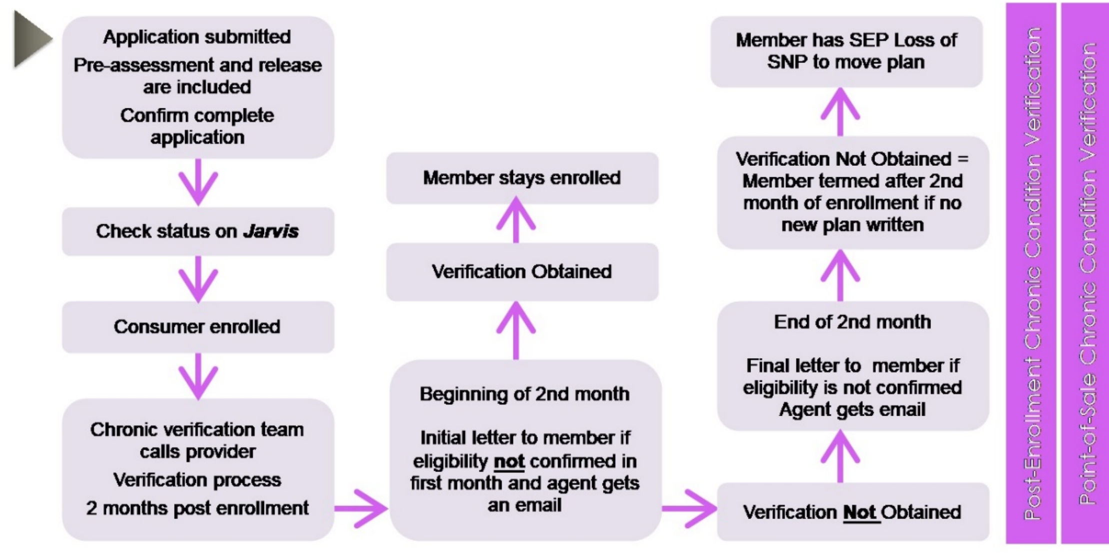
- Agents can assist the consumer/member in submitting proof of eligibility, such as a copy of their Medicaid card or awards letter. For an ID card to be valid proof of Medicaid it has to have an issue date on it and that date has to be within the last 12 months.
- If a copy of the card or awards letter is not available, agents can assist the consumer/member in contacting the state for a copy.

Post-Enrollment Chronic Condition Verification

Point-of-Sale Chronic Condition Verification

Post-Enr CC Veri (Slide Layer)

Post-Enrollment Chronic Condition Verification Process for UnitedHealthcare Branded Plans



POS CC Veri (Slide Layer)

Point-of-Sale Chronic Condition Verification

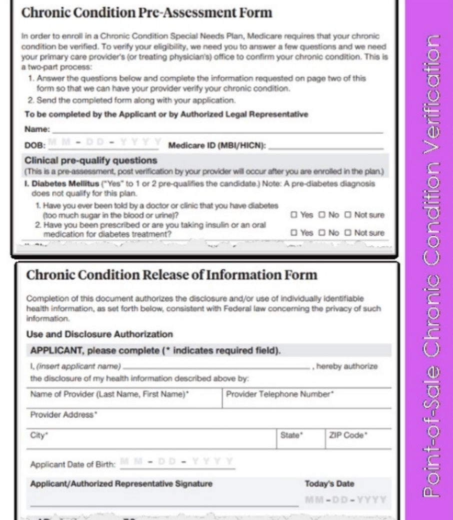
Post-Enrollment Chronic Condition Verification

Chronic Condition Verification At the Point-of-Sale

- **Agents must fill out the Pre-Assessment Form and a Chronic Condition Release of Information Form. These must accompany the submitted enrollment application. The form is in all 2020 Chronic Condition enrollment guides or within the LEAN application. There are different forms for each plan.**

Chronic Condition Verification Agent Involvement

- **Agent involvement is voluntary. UnitedHealthcare will attempt to verify the chronic condition listed on the Chronic Condition Release of Information Form within the allotted time for verification. Agents receive courtesy emails that correlate with the Initial and Final Notice letters sent to the member if attempts to verify eligibility are unsuccessful.**
- **Agents can assist in obtaining the chronic illness verification by providing the physician listed on the Chronic Condition Release of Information Form a copy of the form and requesting he/she fill it out and return it using the instructions located on the bottom of the form. This can be done any time after the sale. This step is optional for the agent to complete as UnitedHealthcare will attempt to verify the chronic condition.**
- **LEAN only requests a release of information and not the verification. For agents using LEAN, there are Chronic Condition Verification Forms located on the Sales Materials Portal. There are 2 UnitedHealthcare and 1 Preferred Care Partner versions of the Chronic Condition Verification Form available; agents should download the applicable form. The forms do contain a direct number to our provider line. This should only be used by providers; agents and consumers should not call the provider line.**
- **UnitedHealthcare will not notify the agent if we have been successful with the verification, only the member will be notified.**



Chronic Condition Pre-Assessment Form

In order to enroll in a Chronic Condition Special Needs Plan, Medicare requires that your chronic condition be verified. To verify your eligibility, we need you to answer a few questions and we need your primary care provider's (or treating physician's) office to confirm your chronic condition. This is a two-part process:

1. Answer the questions below and complete the information requested on page two of this form so that we can have your provider verify your chronic condition.
2. Send the completed form along with your application.

To be completed by the Applicant or by Authorized Legal Representative

Name: ____________________

DOB: MM - DD - YYYY **Medicare ID (MBI/HICN):** ____________________

Clinical pre-qualify questions
(This is a pre-assessment, post verification by your provider will occur after you are enrolled in the plan.)

I. Diabetes Mellitus ("Yes" to 1 or 2 pre-qualifies the candidate.) Note: A pre-diabetes diagnosis does not qualify for this plan.

1. Have you ever been told by a doctor or clinic that you have diabetes (too much sugar in the blood or urine)? ☐ Yes ☐ No ☐ Not sure
2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? ☐ Yes ☐ No ☐ Not sure

Chronic Condition Release of Information Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

Use and Disclosure Authorization

APPLICANT, please complete (* indicates required field).

I, *(insert applicant name)* ____________________, hereby authorize the disclosure of my health information described above by:

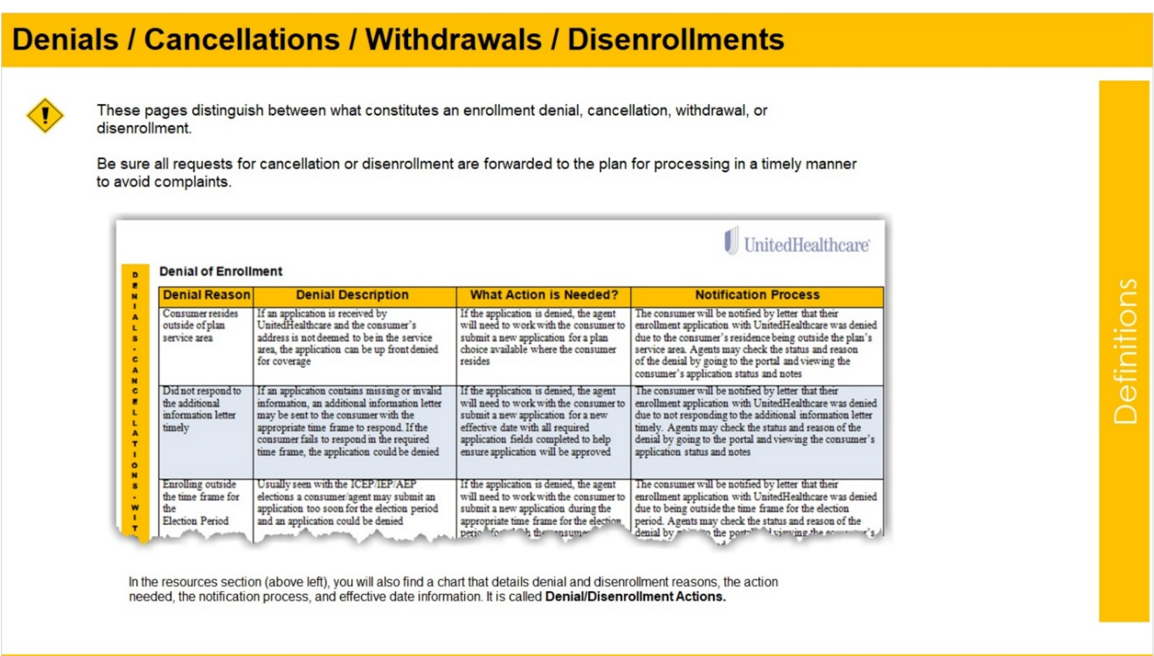
Name of Provider (Last Name, First Name)*	Provider Telephone Number*	
Provider Address*		
City*	State*	ZIP Code*

Applicant Date of Birth: MM - DD - YYYY

Applicant/Authorized Representative Signature **Today's Date** MM-DD-YYYY

Point-of-Sale Chronic Condition Verification

1.15 Denial-Cancel-With-Disenroll



Denial of Enrollment

Denial Reason	Denial Description	What Action is Needed?	Notification Process
Consumer resides outside of plan service area	If an application is received by UnitedHealthcare and the consumer's address is not deemed to be in the service area, the application can be up front denied for coverage	If the application is denied, the agent will need to work with the consumer to submit a new application for a plan choice available where the consumer resides	The consumer will be notified by letter that their enrollment application with UnitedHealthcare was denied due to the consumer's residence being outside the plan's service area. Agents may check the status and reason of the denial by going to the portal and viewing the consumer's application status and notes
Did not respond to the additional information letter timely	If an application contains missing or invalid information, an additional information letter may be sent to the consumer with the appropriate time frame to respond. If the consumer fails to respond in the required time frame, the application could be denied	If the application is denied, the agent will need to work with the consumer to submit a new application for a new effective date with all required application fields completed to help ensure application will be approved	The consumer will be notified by letter that their enrollment application with UnitedHealthcare was denied due to not responding to the additional information letter timely. Agents may check the status and reason of the denial by going to the portal and viewing the consumer's application status and notes
Enrolling outside the time frame for the Election Period	Usually seen with the ICEP/IEP/AEP elections a consumer/agent may submit an application too soon for the election period and an application could be denied	If the application is denied, the agent will need to work with the consumer to submit a new application during the appropriate time frame for the election [illegible]	The consumer will be notified by letter that their enrollment application with UnitedHealthcare was denied due to being outside the time frame for the election period. Agents may check the status and reason of the denial by [illegible]

Definitions (Slide Layer)

Denial

Denial
Consumer is deemed ineligible based on the Centers for Medicare & Medicaid Services (CMS) guidelines (e.g., does not have Parts A and B eligibility or does not live in the service area) or consumer does not respond to the additional information letter within the required time frame; therefore, the enrollment is denied.

Cancel
Consumer is eligible for coverage and enrollment application is approved by CMS; however, prior to the effective date of enrollment the consumer requests a cancellation of coverage. The request can be verbal as long as it is received prior to the effective date of coverage.

Withdrawal
A consumer may request for their application be withdrawn while UnitedHealthcare is still processing the application. A withdrawn application can only occur if the application has not been submitted to CMS and it is prior to the effective date of the coverage. This can be a verbal request.

If the agent accepted a paper enrollment application from the consumer, but has not submitted it to UnitedHealthcare, the agent must return the application to the consumer at the consumer's request. If the application has already been submitted or the application has not been uploaded in the LEAN tool, the agent must upload the application and direct the consumer to call Customer Service and request a cancellation.

Involuntary Disenrollment
A member may be involuntarily disenrolled after their enrollment application has been approved.
CMS defines these disenrollments as involuntary because the member does not elect the disenrollment rather CMS determines the member to be ineligible for the coverage they have elected. Involuntary disenrollment codes are specified based on plan type.

Voluntary Disenrollment
A member may have the option to voluntarily disenroll from their MA/MAPD or PDP plan under certain circumstances. The member can disenroll by submitting a written request through the mail or facsimile, submitting a request via Internet, enrolling in another MA or PDP plan, or by calling 1-800-MEDICARE.

If a disenrollment form or written request is received from the member, the member must provide a valid disenrollment reason (see *Denial/Disenrollment Actions* above) and a valid election period to disenroll. If a valid disenrollment reason is not provided, the disenrollment request may be delayed as UnitedHealthcare takes the time to reach out to the member to obtain a valid reason or the request could be denied if a disenrollment reason cannot be verified.

Definitions

1.16 Paper Application Errors

Paper Application Errors

Missing Information Notification
The Additional Information Letter (AIL) is sent to the consumer for missing information or verification that is needed to complete processing of their application. The Additional Information Letter (AIL) will be sent to the consumer with date by which the missing information is needed.

Agents receive a daily email communication that contains the missing information needed to process the consumer's application. Agents can contact the Producer Help Desk and provide the missing information to UnitedHealthcare.

"Email Communication"

From: "UnitedHealthcare Medicare Solutions"
Date: November 15, 2018
To:
Subject: New or Completed Enrollment Applications

If the agent is able to impact the pending application by providing the missing information/verification needed, please fill out the Missing/ Incomplete Application Update Request form (Jarvis\Enrollment\Application Status).

Timeframes to Supply Missing Information
With the exception of a missing election period, agents must provide the missing application information within 21 days of the receipt of application (in the agent's hands) or the end of the month, whichever is longer.

If an application is pending, get the information to us quickly and watch the pending status. You only have 21 days (or end of month) to get us the complete information.

What The Consumer Corrects

What The Agent Corrects

Pend code descriptions are provided in the resources located at the top of the page.

Consumer (Slide Layer)

What can the consumer correct on an application?

Typographical/Data entry errors:
- Items that can be verified on the original paper application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors. (e.g. transposed numbers/letters - i.e. Terrace vs. Terrcae)

Items that can be verified by Medicare System:
- Medicare Beneficiary Identifier (MBI)
- Name
- DOB (Date of Birth)
- DOD (Date of Death)
- Gender**
- Eligibility Date of Part A, B and/or D
- LIS (Low Income Subsidy) Status

Items not answered on the application:
- Plan not selected, consumer must attest to plan selection
- Multiple plan selection, consumer must attest to plan selection
- Address - physical or mailing
- Signature of consumer
- Phone number
- Email address
- Emergency contact
- Election Period not provided/invalid election period
- Secondary Medical Coverage Values
- Medicaid Number
- Language Preference
- Materials Format
- SPAP Eligibility (State Pharmaceutical Assistance Plan)
- Proposed effective date (must meet requirements of election period)
- PCP (Primary Care Physician/Provider)

How does the consumer make the correction?

Monday through Friday 7am - 8pm CT:
Contact Pre-enrollment at 866-479-0059

Saturday, Sunday, and Holidays:
Contact Member Services
MA/PD: East Coast 800-643-4845
West Coast 800-950-9355
PDP: 888-867-5575

What The Consumer Corrects

What The Agent Corrects

Agents (Slide Layer)

What can the agent correct on an application?

What The Consumer Corrects

Typographical/Data entry errors:
- Items that can be verified on the original paper application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors. (e.g. transposed numbers/letters - i.e. Terrace vs. Terrcae)

Items that can be verified by Medicare System: (NOTE: UnitedHealthcare can verify the information from the agent however cannot provide the information to the agent)
- Medicare Beneficiary Identifier*
  Note: HICN no longer used as of 2020
- Name
- DOB (Date of Birth)**
- DOD (Date of Death)
- Gender**
- Eligibility Date of Part A, B and/or D*
- LIS (Low Income Subsidy) Status*

*Can also be verified by PHD
**PHD will advise if DOB or Gender is incorrect but will not provide the correct information

Items not answered on the application:
- Election Period not provided/invalid election period
- Medicaid Number
- SPAP Eligibility (State Pharmaceutical Assistance Plan)

When is a new application required?
A new application is required in the following scenarios:
- Incorrect Plan Selection
- Plan selection not available in region
- Incorrect selection of county/region
- Missing information not provided within required time frame

How does the agent make the correction?
- Complete the Missing/Incomplete Application Update Request form found on ***Jarvis***
  - Submit the form via email to icssupport@uhc.com or print and fax to 866-802-6062
- Contact Producer Help Desk (PHD) Pre-Enrollment Monday through Friday 7am - 9pm CT at 888-381-8581, Option 1 [Pre-Enrollment]

What The Agent Corrects

1.17 Coordination of Benefits (COB)

Coordination of Benefits (COB)

Below is information surrounding the medical Coordination of Benefits (COB) process that a member might enter when they have coverage through another carrier. The rules and guidelines for COB are set by the Centers for Medicare and Medicaid Services.

How does a member enter into the COB process?
Members are placed in the COB process when they indicate on their enrollment application that they have other coverage such as a commercial plan through their spouse's employer or Veterans Benefits/Tricare. UnitedHealthcare will also implement processes to identify members who may have other coverage and complete an outbound call to the carriers to confirm coverage status on behalf of the member.

Why does UnitedHealthcare need to know about other coverage a member may have?
UnitedHealthcare is responsible for determining, at the time of enrollment, whether a member is also enrolled in a second medical coverage plan either through their spouse or their employer. Active enrollment into a second medical plan for the member is crucial in determining which coverage plan will pay primary for medical services and which will pay secondary. Obtaining this information is beneficial to the member as it will result in less financial responsibility on the part of the member. Example: If a member has a spouse that is still working and therefore has coverage through their employer and the member is a dependent on that policy, the commercial policy may pay primary for any medical services. This would allow UnitedHealthcare to pay as secondary and in many cases lead the member to only have to pay any applicable copays based on their plan details. If the member only has one plan listed on their account, they may be responsible for copays and high deductible amounts.

Once COB has been identified, what are the next steps?
UnitedHealthcare will enter the other coverage information with the confirmed effective dates into the claims processing systems. Consumers will provide both their ID cards to the receptionist at the time of medical treatment. When UnitedHealthcare receives the claim for processing, coordination of benefits rules will apply and determining if the other carrier needs to pay the claim first. If so, the provider is contacted to submit the claim to the primary carrier first and then resubmit the claim with the appropriate documentation indicating the claim has been processed by the primary carrier. UnitedHealthcare will then process the claim as a secondary carrier and send any remaining balance back to the provider indicating member responsibility.

What if the member feels that COB has been entered in error or has now terminated?
If a member feels there is an error on their account related to COB, either the member or the member along with the agent may place a call to the customer service number located on the back of their insurance card. When speaking to a Customer Service representative, simply indicate that you have an error on a medical COB edit and that your other coverage has terminated (provide date) or was added in error and you do not have any other coverage. The Customer Service representative will submit the request over to the internal Coordination of Benefits team to research and update if necessary. Standard COB requests take 30 days to process; however, if there is an urgent need to get a quick response such as claims are being delayed or member is being repeatedly called by their provider, an escalated request can be submitted that has a 48-72 hour turnaround time for a response and can be tracked. Please note: If the request is the first time such a request has been submitted, please make sure to wait the full 30 days for processing prior to initiating an escalated request.

What information should be entered on the enrollment application in order to indicate secondary medical coverage for the member?
The enrollment application form has a field specific to secondary medical coverage. Here agents can enter in the name of the insurer, the policy and group number as well as a phone number if available. There is also a section to indicate the effective date of the coverage. Please ensure that all fields are filled in if the member indicates they have other coverage and is able to provide you with their insurance card. If the member does not have their insurance card, attempt to record as much information as you can to assist UnitedHealthcare in determining COB.

There is also some standard formatting that agents can follow when entering this information. For insurance carrier names, refer to the common list below. If the carrier is not listed below, please ensure you write the full name of the carrier within the field on the application.

- BCBS of "State"
- Humana
- Cigna
- Coventry
- Tricare
- Veterans Benefits or VA Benefits
- Medicaid
- Aetna
- Blue Shield of "State"
- Blue Cross of "State"
- Empire

1.18 Premium and Billing

Payment of Premium / Billing Options

Below is information surrounding the payment of premium process members have available to them when enrolling in a UnitedHealthcare plan. CMS sets billing rules and guidelines. Agents are not to collect any premiums when completing the enrollment application with the member. This is the responsibility of UnitedHealthcare Operations only. All payment options are available in paper applications and all except online are available in LEAN.

What are the methods of payment a member can select?

Electronic Funds Transfer (EFT) - member elects to have their payment automatically drafted from the bank (UnitedHealthcare preferred method). The consumer/member must sign within the "How Do You Want to Pay" section when selecting EFT as the payment method.

- No cost to them
- Eliminates the need for members to write and mail a check on a monthly basis
- As soon as the member receives their member ID card, they should go online and set up their EFT payments
- Monthly payment withdrawal occurs the same time every month, which eliminates the risk of the member receiving notices regarding late payments
- The first EFT occurs the first of the month following the request; if requested within the last five business days of the month, it gets pushed out another month (for example, an enrollment submitted on September 26 would be pulled on November 1)

Online - member elects to make their premium payments online via EFT either monthly or set it up as recurring (no credit cards allowed online). Selecting this option routes the member to either aarpmedicareplans.com or uhcmedicaresolutions.com.

Note: Online payments are not available for Medica, Preferred Care, Erickson, and all SNP Plans. Online payments are only available on paper applications, not LEAN.

Social Security Administration (SSA) or Railroad Retirement Board (RRB) - member elects to have their payment automatically deducted from their SSA or RRB benefit

- There are cutoff dates for SSA and RRB withdrawal; enrollments beyond the cutoff date result in withdrawal starting the month after the effective month
- A direct bill is sent for payment until SSA or RRB is approved via CMS
- It can take longer than one month for CMS to approve SSA or RRB as a withdrawal
- CMS can deny/reject the request for this method of payment

Payment Options (Enrollment Application) | Member Monthly Statement | Member Billing Messages

- CMS can deny/reject the request for this method of payment
- CMS may approve SSA or RRB as a method of payment, but have a lag getting the member set up in their system; they could take out more than one month premium in the event of a lag on their end (the limit is $300)

Direct Pay (by mail) - member is responsible for submitting their own payment
If a member selects direct pay, when will the member receive their bill?

- Each member is assigned a bill cycle (1 through 5)
- A member can change their billing cycle; however, no changes can be made while the bill cycle is running (between the 4th and the 8th)
- In exception cases, billing operations may perform a bill adjustment that creates a new bill outside of the bill cycle. The member will need to contact customer service.

Bill Cycle	Bill Date	Estimated Mail Date
1	4th	7th
2	5th	8th
3	6th	9th
4	7th	10th
5	8th	11th

Recurring Credit Card - member elects to have their payment automatically paid via their debit/credit card monthly

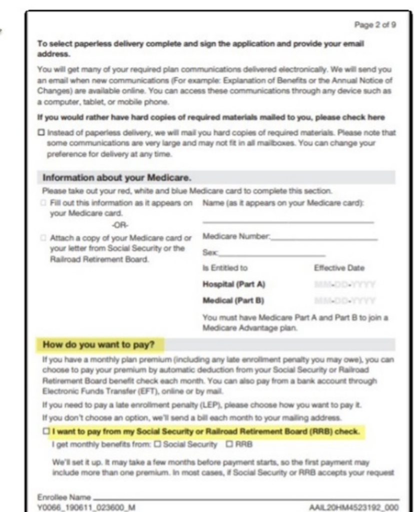
- No cost to them
- Eliminates the need for members to write and mail a check on a monthly basis
- Monthly payment withdrawal occurs the same time every month, which eliminates the risk of the member receiving notices regarding late payments

Note: This option is not listed on the paper application for data security reasons. If a member wants to pay by recurring credit card, they need to call customer service.

For Information on MA Plan ANOCs, please review the resource provided at the top of the screen in the resources tab

Payment Options (Slide Layer)

Payment Options on Enrollment Application



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To select paperless delivery complete and sign the application and provide your email address.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

If you would rather have hard copies of required materials mailed to you, please check here

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Information about your Medicare.

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 Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): ______________

Medicare Number: ______________

Sex: ______________

Is Entitled to	Effective Date
Hospital (Part A)	MM-DD-YYYY
Medical (Part B)	MM-DD-YYYY

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

How do you want to pay?

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT), online or by mail.

If you need to pay a late enrollment penalty (LEP), please choose how you want to pay it.

If you don't choose an option, we'll send a bill each month to your mailing address.

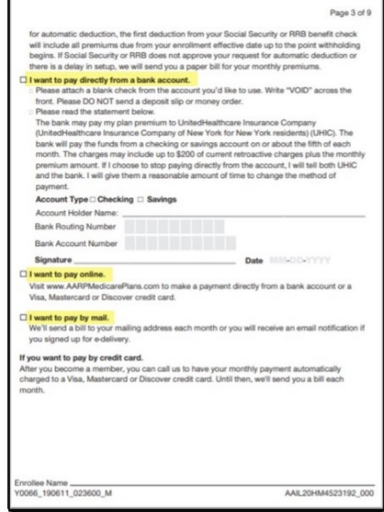
☐ **I want to pay from my Social Security or Railroad Retirement Board (RRB) check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

We'll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request

Enrollee Name ______________

Y0066_190611_023600_M AAIL20HM4523192_000



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for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or there is a delay in setup, we will send you a paper bill for your monthly premiums.

☐ **I want to pay directly from a bank account.**

☐ Please attach a blank check from the account you'd like to use. Write "VOID" across the front. Please DO NOT send a deposit slip or money order.

☐ Please read the statement below.

The bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). The bank will pay the funds from a checking or savings account on or about the fifth of each month. The charges may include up to $200 of current retroactive charges plus the monthly premium amount. If I choose to stop paying directly from the account, I will tell both UHIC and the bank. I will give them a reasonable amount of time to change the method of payment.

Account Type ☐ **Checking** ☐ **Savings**

Account Holder Name: ______________

Bank Routing Number

Bank Account Number

Signature ______________ **Date** MM-DD-YYYY

☐ **I want to pay online.**

Visit www.AARPMedicarePlans.com to make a payment directly from a bank account or a Visa, Mastercard or Discover credit card.

☐ **I want to pay by mail.**

We'll send a bill to your mailing address each month or you will receive an email notification if you signed up for e-delivery.

If you want to pay by credit card.

After you become a member, you can call us to have your monthly payment automatically charged to a Visa, Mastercard or Discover credit card. Until then, we'll send you a bill each month.

Enrollee Name ______________

Y0066_190611_023600_M AAIL20HM4523192_000

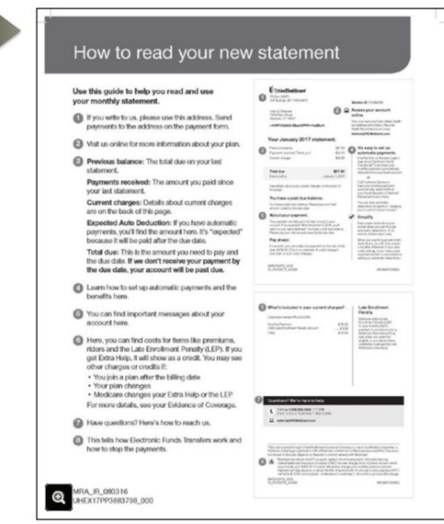
Payment Options (Enrollment Application)

Member Monthly Statement

Member Billing Messages

Statement (Slide Layer)

Member Monthly Statement Sample



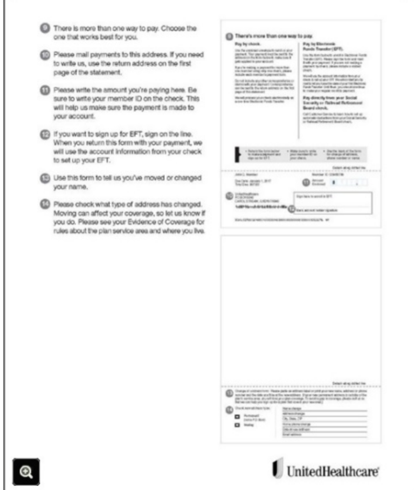
How to read your new statement

Use this guide to help you read and use your monthly statement.

1. If you write to us, please use this address. Send payments to the address on the payment form.
2. Visit us online for more information about your plan.
3. **Previous balance:** The total due on your last statement.
   Payments received: The amount you paid since your last statement.
   Current charges: Details about current charges are on the back of this page.
   Expected Auto Deduction: If you have automatic payments, you'll find the amount here. It's "expected" because it will be paid after the due date.
   Total due: This is the amount you need to pay and the due date. **If we don't receive your payment by the due date, your account will be past due.**
4. Learn how to set up automatic payments and the benefits here.
5. You can find important messages about your account here.
6. Here, you can find costs for items like premiums, riders and the Late Enrollment Penalty (LEP). If you get Extra Help, it will show as a credit. You may see other charges or credits if:
   - You join a plan after the billing date
   - Your plan changes
   - Medicare changes your Extra Help or the LEP

   For more details, see your Evidence of Coverage.
7. Have questions? Here's how to reach us.
8. This tells how Electronic Funds Transfers work and how to stop the payments.

MRA_IR_080316
UHEX17PP3883798_000



9. There is more than one way to pay. Choose the one that works best for you.
10. Please mail payments to this address. If you need to write us, use the return address on the first page of the statement.
11. Please write the amount you're paying here. Be sure to write your member ID on the check. This will help us make sure the payment is made to your account.
12. If you want to sign up for EFT, sign on the line. When you return this form with your payment, we will use the account information from your check to set up your EFT.
13. Use this form to tell us you've moved or changed your name.
14. Please check what type of address has changed. Moving can affect your coverage, so let us know if you do. Please see your Evidence of Coverage for rules about the plan service area and where you live.

UnitedHealthcare

Member Monthly Statement

Member Billing Messages

Messages (Slide Layer)

Member Billing Messages

Payment Options (Enrollment Application) | Member Monthly Statement | Member Billing Messages

The following are customized messages that could display on a member's bill
Up to four customized messages can be displayed on a monthly bill. MOP stands for Method of Payment.

Message Name (members will not see this)	What members will see
Monthly premium change	The amount that you owe has changed. See back for details
Paid in advance/credit balance exists	You have a credit balance. No payment is due at this time
Members on Payment Plans	You set up a payment plan with us to make up missed payments. Thank you. If you miss a payment, the payment plan is canceled
Bankruptcy	The amount due is not included in your bankruptcy filing. It is for charges you own after your bankruptcy filing date. You will need to pay this amount
Payment method change SSA/RRB	Starting <MOP_EFFECTIVE_DATE>, your Social Security or Railroad Retirement Board will make your payments
Payment method change EFT	Starting <MOP_EFFECTIVE_DATE> your charges will be paid directly from your bank as an electronic funds transfer (EFT). Payment will take place on or about the 5th of each month. If the 5th falls on a holiday or weekend, payment will take place on the next business day
Payment method change Direct Bill	We are confirming that you want to begin paying by check <MOP_EFFECTIVE_DATE>. Thank you
Past due balance	You have a past due balance. Please pay your total amount owed by the due date
Escalated past due balance	Your payment is late. Please pay the amount due so you don't face further action
Termed Members	You are no longer covered by the plan. Please pay amount shown. If we do not receive payment in 60 days, your balance may be forwarded to a collection agency.
Estimated plan year Premium	If you wish, you can make one payment for the rest of the year: <EST_PLAN_YR_PREM> (This is an estimate. It could change if your plan or your costs change)
Paid in advance Paid through plan year	Your plan is paid for the rest of the year. If your plan changes, you may owe more or have a credit. If that happens, we'll send you a bill

1.19 Non-Payment of Premium

Non-Payment of Premium

Terminations for nonpayment of premium currently only occur for members in a stand-alone prescription drug plan (PDP); however, Medicare Advantage (MA) members can be impacted. If UnitedHealthcare has terminated a member for nonpayment of premium, they cannot enroll in any UnitedHealthcare plan until they pay in full or pay at least half of their outstanding balance and set up a payment plan. If a member is being denied enrollment and doesn't understand why, this could be the reason. You can set up a 3-way call between you, the member, and member services to learn more about the enrollment denial reason.

Below is information surrounding the Non Payment of Premium (NPOP) process that a member might enter if they fail to pay their monthly plan premium. The Rules and Guidelines for NPOP are set by CMS.

How does a member enter into the NPOP process?
- Members are placed in the NPOP process when they fail to pay their monthly plan premium or Late Enrollment Penalty that is assessed due to a gap in Part D coverage.

How does a member determine their premium owed?
- UnitedHealthcare is responsible for determining, at the time of enrollment, whether a member has enrolled in a plan that requires a monthly premium and the payment method the member has selected in order to pay their monthly premiums timely. If the member did not choose a method of payment at time of enrollment, UnitedHealthcare will default the member to a monthly invoice statement. The invoice statement will have listed at the top the amount of premium that the member needs to pay as well as a tear off at the bottom of the first page for the member to submit with payment back to UnitedHealthcare.

Once a member has entered the NPOP process, what are the next steps?
- UnitedHealthcare will inform the member via letter about the risk of termination due to non-payment of premium as well as the next steps. The member can contact UnitedHealthcare customer service and either pay the balance in full or set up a repayment plan to avoid termination during the two month grace period. The invoice statement will have a tear off section that a member can fill out and submit with their payment in full to avoid termination.
- If UnitedHealthcare receives a returned payment from the financial institution, the member will be at risk for termination from their coverage if an acceptable payment is not remitted to UnitedHealthcare prior to the end of the grace period.
- If the member fails to follow through with their agreed payment plan, the member will have one additional chance to set up a new repayment plan within a contract year (Jan - Dec) to avoid termination.

What if the member has a Good Cause on why they are unable to pay their premium?
- If a member feels they have a good reason on why they are unable to pay their premiums, the member needs to contact UnitedHealthcare to initiate a Good Cause case.

How does a member enter the downgrade process?
- Members are placed in the downgrade process when they fail to pay their monthly optional rider premium.

Once a member has entered the NPOP or downgrade process, what are the next steps?
- UnitedHealthcare will inform the member via letter about the risk of termination due to non-payment of premium or loss of their optional rider coverage as well as what the next steps are including the risk of termination or loss of optional benefit.
- The member can contact UnitedHealthcare customer service and either pay the balance in full or setup a repayment plan to avoid termination during the two month grace period.
- The invoice statement will have a tear off section that a member can fill out and resubmit with their payment in full to avoid termination.

1.20 Late Enrollment Penalty

Late Enrollment Penalty

Below is information surrounding the Late Enrollment Penalty (LEP) that a member might incur if they delay their enrollment into a Part D plan. The rules and guidelines for LEP are set by CMS.

Who incurs a Late Enrollment Penalty?

- A member may incur an LEP if, at any time after they become eligible for Part D coverage, there is a period of 63 or more continuous days without creditable prescription drug coverage. Creditable prescription drug coverage is defined as coverage that meets Medicare's minimum standards or pays on average at least as much as Medicare's standard prescription drug coverage.

Who determines the Late Enrollment Penalty?

- UnitedHealthcare is responsible for determining, at the time of enrollment, whether a member was previously enrolled in a Medicare prescription drug plan or had other creditable coverage and whether there are any lapses in coverage of 63 days or more. UnitedHealthcare will then notify CMS of the lapses and CMS will determine the LEP amount to be applied to the member's account. Any member eligible for low income subsidy (LIS) is not subject to a LEP.

Once a Late Enrollment Penalty has been determined what are the next steps for the member?

- UnitedHealthcare will inform the member via letter about the LEP as well as what the next steps are. The member will receive an attestation form with instructions to fill out the form and submit to UnitedHealthcare or the member can contact UnitedHealthcare's Customer Service department and attest to the creditable coverage. The member will need to attest to the exact dates they had creditable coverage as well as with whom they had creditable coverage (e.g., VA benefits). The member will have 30 days to respond to UnitedHealthcare with this information. UnitedHealthcare may send the member a reminder notice as the end of the 30 days is approaching.
  - Example: I had coverage through my employer Boeing from August 1, 1995 - January 31, 2014
  - Example: I had VA coverage from November 1,1997 - December 31, 2013
- If UnitedHealthcare receives an incomplete attestation (the start and end dates are missing or the type of coverage is missing) or an attestation is not received, UnitedHealthcare will follow up with the member via letter to obtain the missing information. The member will have up to 60 days after the 30 day deadline stated in the initial notice to provide UnitedHealthcare with an attestation.
- If UnitedHealthcare receives a response after 60 days from the initial deadline, UnitedHealthcare will be unable to accept the attestation and will inform the member of this via letter. UnitedHealthcare will inform the member of the LEP that will be placed on their household as well as the steps to take for reconsideration through Maximus. Maximus is CMS' independent review entity: they will notify UnitedHealthcare of the final decision upholding, reducing or eliminating the LEP amount. UnitedHealthcare will make the adjustments and send the notification to the member of the final outcome.

What causes an Attestation to be deemed incomplete?

- Consumer does not state the full time period (start and end date of coverage)
- Consumer does not sign a submitted attestation form
- Consumer does not state what type of coverage they had (VA, Employer etc.)

1.21 Out of Area

Out of Area

Below is information surrounding the Out of Area (OOA) process that a member might enter if they fail to notify UnitedHealthcare of a change of address or UnitedHealthcare receives returned mail from the United States Postal Service (USPS). The Rules and Guidelines for OOA are set by CMS. During the enrollment process, be sure to remind the consumer to notify UnitedHealthcare if they move.

How does a member enter into the OOA process?

- Members are placed in the OOA process when they fail to notify UnitedHealthcare of a change of address and UnitedHealthcare receives returned mail from USPS.
- CMS will notify us via a transaction reply code if the member no longer resides in the service area for the plan in which they are enrolled.
- State and County Code (SCC) Discrepancy Report

Once a member enters the OOA process, what are the next steps?

- UnitedHealthcare informs the member via letters about the risk of termination due to the member residing outside the service area. The member is notified via letter for six months if enrolled in a MA/MAPD product and twelve months for a PDP product. The member can contact UnitedHealthcare's Customer Service department and update their address with UnitedHealthcare if they still reside in the service area. If the member has moved to a new plan service area, the member can work with their agent or can be transferred to Telesales to submit a new application for that service area.
- The Agent of Record is notified by secure email when a member they enrolled is in the final phase (i.e. termination) of the out-of-area process. Members at this point have until the end of the current month to update their address with UnitedHealthcare before their coverage is terminated.

It is possible that a member is placed in the OOA process and they have not moved. UnitedHealthcare likely received returned mail that placed the member in OOA. The member needs to contact UnitedHealthcare to confirm their street address and county information to prevent termination of their enrollment.

1.22 Natural Disasters/FEMA

Natural Disasters/FEMA

To determine a valid election period and effective date during a natural disaster, go to www.fema.gov/disasters. Most recent disasters will be listed or you can narrow the list by completing the fields.

- Complete the fields for state, declaration type (select major disaster declaration) and incident begin month and year
- Click Apply
- Results will appear right below "apply'

Review the Incident Period start date to determine if the application is within four (4) months from the start date. In the screen shot shown here, the incident period is May 11, 2018, to May 13, 2018. The member would have June, July, August, and September to submit the application. The effective date would be the next available effective date per the received date.

If within the 4 months, click on the link of the Incident listed. On the right hand side of the map, it will specify if the entire state is eligible or specific counties. In the example shown here, the entire state of Alaska is eligible.

FEMA

Disasters

Navigation

Search

Languages

Total number of declared disasters: by State/Tribal Government and by Year.

State/Tribal Government: Alaska

Incident Type: - Any -

Declaration Type: Major Disaster Declaration

Incident Begin Date: May 2018

Incident End Date: -Month -Year

Apply Reset

Alaska Flooding (DR-4391)

Incident period: May 11, 2018 to May 13, 2018

Major Disaster Declaration declared on September 05, 2018

FEMA-4391-DR, Alaska Disaster Declaration as of 09/05/2018