Chronic Condition Special Needs Plan (SNP) Pre-Qualification Assessment

Last Name _____ First Name _____ MI _____

Medicare Number _____ Date of Birth _____

CLINICAL QUALIFYING QUESTIONS FOR DIABETES

If the applicant answers "Yes" to any of the following questions, then he or she pre-qualifies for SNPs targeting enrollees with diabetes.

1. Have you ever been told that you have high blood sugar or diabetes? Yes No
2. Have you ever or do you currently measure/monitor your blood sugar? Yes No
3. Have you been prescribed or do you take insulin or an oral medication that's supposed to lower your blood sugar? Yes No

MEDICATION QUESTION What medicines do you take for diabetes? _____

CLINICAL QUALIFYING QUESTIONS FOR CARDIOVASCULAR DISORDER

If the applicant answers "Yes" to any of the following questions, then he or she pre-qualifies for SNPs targeting enrollees with cardiovascular disorders (CVD).

1. Do you have a problem with your heart, had a heart attack, or have you been told that you had a heart attack? Yes No
2. Do you have a problem with your circulation or have you been told that you have problems with your circulation? Yes No
3. Do you have pain in your legs when you walk that gets better when you stop and rest? Yes No

MEDICATION QUESTION What medicines do you take for CVD? _____

CLINICAL QUALIFYING QUESTIONS FOR CHRONIC HEART FAILURE

If the applicant answers "Yes" to any of the following questions, then he or she pre-qualifies for SNPs targeting enrollees with chronic heart failure (CHF).

1. Have you ever been told you have heart failure or congestive heart failure? Yes No
2. Have you ever been told you have fluid in your lungs? Yes No
3. Have you ever been told you have swelling in your legs due to your heart? Yes No

MEDICATION QUESTION What medicines do you take for CHF? _____

CLINICAL QUALIFYING QUESTIONS FOR CHRONIC LUNG DISORDER

If the applicant answers "Yes" to any of the following questions, then he or she pre-qualifies for SNPs targeting enrollees with chronic lung disorders (Asthma, Chronic Bronchitis, Emphysema, Pulmonary Fibrosis, and Pulmonary Hypertension).

1. Do you have any chronic breathing problems? Yes No
2. Have you ever been told you have a lung problem such as emphysema, asthma, chronic bronchitis, scarring in the lung, or high pressure in the lungs? Yes No
3. Do you use inhalers or other medicines for your breathing more than 3 times per week? Yes No

MEDICATION QUESTION What medicines do you take for chronic lung disorder? _____

By filling this oval, I consent to Humana contacting my provider(s) to confirm my chronic condition(s).

Primary Care Physician/
Specialist Name _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

Applicant Signature _____ Date _____

This plan is available to individuals with certain chronic conditions. To qualify for a Chronic Condition Special Needs Plan, physician diagnosis of the condition must be verified. Enrollees who do not have the condition will be disenrolled.

Humana.

Verification of Chronic Condition (VCC)

The member listed below has enrolled in a Humana Medicare Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to Humana right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name:_____ Date of Birth:_____

Address:_____

Humana ID:_____ Medicare ID:_____

Proposed Effective Date: _____

My signature below authorizes information about my chronic condition to be shared with Humana. Note: While Humana does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

To Be Completed by the Physician/Physician's Office

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

- ☐ None
- ☐ Diabetes
- ☐ Chronic Heart Failure
- ☐ Chronic Lung Disease: Asthma, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension
- ☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to Humana:

- Via the **Availity** provider portal, or
- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **VCC@humana.com**, or
- Call us at **1-877-271-5229** to provide verbal verification.
- (Monday – Friday, 8 a.m. to 6 p.m., Eastern time)