Chronic Condition Pre-Assessment Form

In order to enroll in a chronic condition special needs plan, Medicare requires that your chronic condition be verified by your primary care provider or treating physician's office. This is a two-part process:

1. Answer the questions below, sign, and complete the information requested on page two under APPLICANT so that we can have your provider verify your chronic condition.
2. Send the completed form along with your application. We will use the form to have your provider confirm your chronic condition.

To be completed by the applicant or by authorized legal representative

Name: _____

DOB: _____ **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 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 or high sugar(s))? ☐ Yes ☐ No
2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? ☐ Yes ☐ No

II. Chronic heart failure

1. Have you ever been told by a doctor or clinic that you have chronic or congestive heart failure (fluid or water in the lungs or heart)? ☐ Yes ☐ No
2. Have you had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem? ☐ Yes ☐ No
3. During the past 12 months, have you been counseled or educated by a health care professional about weighing yourself daily to monitor a heart problem? ☐ Yes ☐ No

III. Cardiovascular disorders

1. Have you been told by a doctor or clinic that you have an irregular heart rate, (such as atrial fibrillation) heart disease, or coronary artery disease? ☐ Yes ☐ No
2. Have you ever been told you have peripheral vascular disease, poor circulation or claudication in your legs? ☐ Yes ☐ No
3. Do you have chronic skin ulcers or vein problems in your legs? ☐ Yes ☐ No
4. Have you ever been prescribed medications to thin your blood like warfarin or clopidogrel for a heart condition? ☐ Yes ☐ No
5. Do you have a pacemaker or internal defibrillator? ☐ Yes ☐ No
6. Have you had angioplasty, stents or bypass on your heart or legs? ☐ Yes ☐ No

Applicant/authorized representative: _____

Completing this pre-assessment does not guarantee enrollment in the plan. All chronic special needs plans require verification from a provider or specialist to be enrolled in the plan.

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: _____

Applicant/authorized representative signature **Today's date**

_____

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Primary care provider/specialist/care provider representative), hereby certify that _____ (applicant) has the following health condition(s):

☐ Diabetes mellitus (pre-diabetes excluded)

☐ Chronic heart failure ☐ Cardiovascular disorders

Primary care provider/treating physician/specialist signature **Today's date**

_____

Please send the completed forms along with your application to:

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

Or fax the front and back of each page to:
1-888-950-1170

If you have any questions, please call:
1-866-367-7527, TTY **711**, 8 a.m.–8 p.m. local time, 7 days a week

Chronic Condition Verification Form

Use and Disclosure Authorization

PRIMARY CARE PROVIDER/TREATING PHYSICIAN/SPECIALIST, please complete.

I,_____ (Primary Care Provider/Specialist/Care Provider Representative), hereby certify that _____ (Applicant) has the following health condition(s):

☐ **Diabetes Mellitus (Pre-diabetes excluded)** ☐ **Chronic Heart Failure**

Care Provider/Specialist Signature: _____ **Date:** MM-DD-YYYY

Provider Telephone Number XXX-XXX-XXXX

By signing below, Applicant authorizes Provider to disclose Applicant's health information (listed above) to UnitedHealthcare, so that UnitedHealthcare can determine Applicant's eligibility for C-SNP plan coverage.

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative	Medicare ID Number (MBI/HICN) or Date of Birth

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

If you are the authorized representative of the applicant, please provide the following information:

Relationship to Applicant	Address	Telephone Number
		XXX-XXX-XXXX

Fax this form to:
1-888-950-1170

Mail this form to:
UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

If you have any questions, please call:
1-866-868-0615, TTY **711**, 8 a.m. – 5 p.m. CT, Monday – Friday

UnitedHealthcare®

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894（TTY：711).

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