GOLD KIDNEY HEALTH PLAN

Gold Kidney Health Plan (HMO C-SNP)
Chronic Condition Verification Form

Provider Name:		
One of your patients has elected to enroll in a Gold Kidney Medicare Advantage Chronic Special Needs Plan (C-SNP). To qualify for continued enrollment in this plan, CMS requires verification from a healthcare provider that the individual has been diagnosed with one or more of the plan-qualifying chronic conditions.		
Patient Information		
Last Name:	**First Name:**	**MI:**
Medicare ID (MBI):	**Date of Birth:**	

Please complete verbal or written verification within 48 hours of receipt. You or your office staff may complete this verification by:

Phone: To provide verbal verification, please contact Gold Kidney Members Services at **(844) 294-6535 (TTY 711), ext. 5013.** We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m. local time, 7 days a week (except holidays), and April 1 through September 30 from 8:00 a.m. to 8:00 p.m. local time, Monday through Friday (except holidays).
Fax: To provide written verification, fax the completed and signed verification form to **(866) 547-1920**.

Chronic Condition Verification

Medicare requires Gold Kidney Health Plan to verify your chronic condition as part of the enrollment process. You must have a qualifying condition to enroll in a Gold Kidney health plan. If you are not seeing a physician today for one of the qualifying conditions in either Heart & Diabetes or Dialysis & Kidney sections below, you may not qualify for our plan. It is important for you to provide us with contact information for a doctor or clinic that can verify your condition. **Note:** If we are unable to verify your chronic condition, we must disenroll you from the C-SNP plan at the end of your second month of enrollment.

Qualifying for Gold Kidney Heart & Diabetes Plans: You must answer "yes" to at least one of the chronic condition questions below to qualify for any Gold Kidney heart & diabetes plan

Have you been diagnosed by your doctor or other licensed healthcare professional with any of the following illnesses?

Blood clots or vascular disease of the legs (CVD)	☐ Yes ☐ No	Coronary artery disease (CAD)	☐ Yes ☐ No
		Diabetes (sugar disease)	☐ Yes ☐ No
Cardiac arrhythmia	☐ Yes ☐ No	Previous heart attack	☐ Yes ☐ No
Congestive heart failure (CHF)	☐ Yes ☐ No	Previous stroke	☐ Yes ☐ No

Have you been prescribed or are you currently taking medication for an illness listed above? ☐ Yes ☐ No

List doctors, clinics, and other healthcare providers who can verify your "Yes" answers.

Provider #1 (Physician Name) *(required)*	Specialty	City

Phone Number:	Fax Number:

Provider #2 (Physician Name)	Specialty	City
Phone Number:	Fax Number:	

Release of Information

Completion of this section authorizes the disclosure and use of individually identifiable information, as set forth below, consistent with Federal Law concerning the privacy of such information.

☐ I herewith authorize and direct Gold Kidney to confirm my chronic conditions and obtain my medical records until I am no longer enrolled in the Gold Kidney Health Plan. ***(Box must be checked for CSNP verification)***

Applicant Name (printed):	Date:
Applicant/Authorized Representative Signature:	Physician Signature:

Qualifying for Gold Kidney Dialysis & Kidney Plans: You must answer "yes" to at least one of the questions below to qualify for any Gold Kidney dialysis & kidney plan

Have you had a blood test showing that you have chronic kidney disease (CKD) at any stage 1-5? ☐ Yes ☐ No

If yes, please select the stage of CKD: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Not sure

If known, what is your eGFR? _____

Are you currently receiving regularly scheduled dialysis? (Either in-home or in-center) ☐ Yes ☐ No

Do you have end-stage renal disease (ESRD) / end-stage kidney disease (ESKD)? ☐ Yes ☐ No

Are you currently taking any of the following types of medications?

Blood pressure	☐ Yes ☐ No	Diabetes (sugar disease)	☐ Yes ☐ No
Blood thinners	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Other	☐ Yes ☐ No

List doctors, clinics, and other healthcare providers who can verify your “Yes” answers.

Primary Nephrologist Name *(required)*	Phone Number	City

Provider #1 (Physician Name)	Specialty	City
Phone Number:	Fax Number:	
Provider #2 (Physician Name)	Specialty	City
Phone Number:	Fax Number:	

Release of Information	
Completion of this section authorizes the disclosure and use of individually identifiable information, as set forth below, consistent with Federal Law concerning the privacy of such information. ☐ I herewith authorize and direct Gold Kidney to confirm my chronic conditions and obtain my medical records until I am no longer enrolled in the Gold Kidney Health Plan. ***(Box must be checked for CSNP verification)***	
Applicant Name (printed):	Date:
Applicant/Authorized Representative Signature:	Physician Signature:

Gold Kidney Office Use Only		
Date Received:	Gold Kidney Representative:	Status:

Gold Kidney Health Plan, Inc.®, is an HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.