HealthSpring℠

Chronic Condition Special Needs Plan (C-SNP) Verification Form

Your provider must complete and sign this form to help us verify your chronic condition. If we do not receive this signed and completed form from your provider before the end of the second month of your enrollment, we will have to disenroll you from the plan.

Your provider, your Licensed Insurance Agent, or you may return this form to us by:

- Mailing it to HealthSpring E&E Team, PO Box 239, Nashville, TN 37202, or
- Faxing it to the attention of Medicare E&E Team at **1-615-695-4358**, or
- Sending an encrypted email to **CSNPVerification@HealthSpring.com** (secure email option is for providers and agents only).

Applicant Information

Last Name	**First Name**	**Middle Initial**

Date of Birth	**Sex**	**Medicare Beneficiary Identifier** (if known)
/ /	☐ Male ☐ Female	

Provider Chronic Condition Verification

Please answer all three questions.

1. **Has your patient been diagnosed with:**
   Cardiovascular disorder? ☐ Yes ☐ No
   Chronic Heart Failure? ☐ Yes ☐ No
   Diabetes? ☐ Yes ☐ No
2. **Is your patient currently taking prescription medication for cardiovascular disorders, chronic heart failure, or diabetes? ☐ Yes ☐ No**
3. **Does your patient currently have signs and/or symptoms of cardiovascular disorders, chronic heart failure, or diabetes? ☐ Yes ☐ No**

Provider Name	**Provider Title**
Provider Signature	**Date**
	/ /

This form must be signed by a physician, physician's assistant, or nurse practitioner.

You must be clinically diagnosed with cardiovascular disorders, chronic heart failure, or diabetes to be eligible for the HealthSpring Achieve (HMO C-SNP) plan and maintain coverage. If you have any questions, call Customer Service at 1-800-668-3813 or 1-800-627-7534 (AZ HMO only) (TTY 711). Our hours are 8 a.m. – 8 p.m. local time: October – March: 7 days a week; April – September: Monday – Friday. Messaging service used weekends, after hours, and on federal holidays.