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

The plan you have selected is designed to meet the needs of people who have cardiovascular disorders, chronic heart failure, or diabetes. Please have your provider complete this form to help us verify your condition. Your provider may return this form to us by mailing it to HealthSpring E&E Team, PO Box 239, Nashville, TN 37202; or by faxing it to the attention of Medicare E&E Team at **1-615-695-4358**; or by sending an encrypted email to **CSNPVerification@HealthSpring.com**.

Applicant Information		
Last Name	**First Name**	**Middle Initial**

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

Please read and sign below:

I (applicant name) ______________________________, hereby authorize the disclosure of my health information by the provider listed on the next page to HealthSpring in order to verify that I have been diagnosed with a cardiovascular disorder, chronic heart failure, or diabetes, thus qualifying me for enrollment in the HealthSpring Medicare Advantage C-SNP. This authorization applies to all health information maintained by the health care provider concerning my medical history or care from (insert date) ______ / ______ / __________ to present for the condition indicated above. This authorization will expire upon the earlier of: 1) my not enrolling in the HealthSpring Medicare Advantage C-SNP for those clinically diagnosed with cardiovascular disorders, chronic heart failure, or diabetes; or 2) the termination of my enrollment in the HealthSpring Medicare Advantage C-SNP.

I understand the following:

- I may cancel this authorization at any time prior to my enrollment in HealthSpring. My cancellation must be in writing, signed by me or by my Authorized Representative, and sent to HealthSpring. HealthSpring will cancel the provider contact when you request it, but only if the request is received before HealthSpring contacts the provider.
- If I refuse this authorization, HealthSpring may reject my enrollment.
- Information disclosed as a result of this authorization will be protected by HealthSpring in accordance with applicable state and federal confidentiality laws and requirements.

Signature of Member/Enrollee or Authorized Representative	**Today's Date**
	/ /

PLEASE COMPLETE AND RETURN BOTH PAGES OF THIS FORM.

If you are the Authorized Representative, you must provide the following information:		
Last Name	**First Name**	**Middle Initial**
Address		
Phone Number	**Relationship to Applicant**	

Chronic Condition Verification

"Yes" to all three questions automatically prequalifies the applicant.

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. 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.

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