CHRONIC SPECIAL NEEDS PLAN (C-SNP) QUALIFICATION VERIFICATION FORM

URGENT ACTION REQUIRED

Clear Spring Health

FIRST AND LAST NAME: _____ MEDICARE NUMBER: _____

ADDRESS: _____ DOB: _____

CITY, STATE, ZIP: _____ PLAN NUMBER: _____

In order to confirm you have the qualifying condition(s) to enroll in our Chronic Special Needs Plan (C-SNP), please visit your physician and have them complete the information.

Please fax to 866-649-6822 or email at **enrollmentdepartment@clearspringhealthcare.com.** You may also mail it to **Enrollment** at **PO Box 3040, Spring Hill, FL 34611**.

To Be Completed by Physicians, Physician's Extenders, Allied Health Providers, and Nurses.

The above applicant has applied to enroll in the Chronic Special Needs Plan offered be their health plan. To qualify for this Plan, the applicant must have one of the following conditions. If you have any questions, please contact us at 1-877-364-4566, Monday through Friday from 8:00am - 8:00pm. During certain parts of the year, we may use alternative technologies to answer your call on weekends and Federal holidays. TTY users can call 711.

We request you to confirm that the applicant has one of the qualifying conditions by placing a checkmark in the appropriate box(es).

- ❑ **Cardiovascular Disease (CVD)**
  Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease
- ❑ **Chronic Heart Failure (CHF)**
- ❑ **Diabetes Mellitus (DM)**

- OR -

- ❑ I **DO NOT** confirm the presence of any condition listed

PHYSICIAN LAST NAME: PHYSICIAN FIRST NAME:

AUTHORIZED SIGNATURE: _____

Must be signed by the physician's office.

TODAY'S DATE: (MM/DD/YYYY)