CHRONIC CONDITION VERIFICATION FORM FOR SPECIAL SUPPLEMENTAL BENEFITS (SSBCI)

PROVIDER ATTESTATION

Clear Spring Health

FIRST AND LAST NAME: _____

MEDICARE BENEFICIARY IDENTIFIER (MBI): _____

DOB: _____

In order to confirm you have the qualifying condition(s) to receive the additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI) on your plan, please visit your physician and have them complete the information below. If you have any questions, please contact us at **877-364-4566 (TTY 711)**, Monday through Friday from 8:00 am to 8:00 pm. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

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

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

The above member has enrolled in a plan that offers additional benefits as part of the Special Supplemental Benefits for the Chronically Ill on their plan. To qualify, the member must have one of the following conditions. We request you to confirm that the member has one of the qualifying conditions by placing a checkmark in the appropriate box(s).

- ❑ Diabetes
- ❑ COPD
- ❑ Chronic Heart Failure
- ❑ Chronic Kidney Disease

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

PHYSICIAN LAST NAME: _____

PHYSICIAN FIRST NAME: _____

AUTHORIZED SIGNATURE: _____

Must be signed by the physician's office.

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

_____

Clear Spring Health has a contract with Medicare to offer HMO and PPO Plans. Enrollment in these plans is dependent on annual contract renewal with the federal government. Y0145_EN F 004-090525_C