

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



**URGENT ACTION REQUIRED**

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 below.

Please fax to 866-649-6822 or email at [enrollmentdepartment@clearspringhealthcare.com](mailto:enrollmentdepartment@clearspringhealthcare.com).  
You may also mail it to **Clear Spring Health Enrollment** at **PO Box 3040, Spring Hill, FL 34611**.

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MEDICARE NUMBER: \_\_\_\_\_  
MAILING ADDRESS \_\_\_\_\_ DOB: \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
ZIP \_\_\_\_\_

## 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 by their health plan. To qualify for this Plan, the applicant must have one of the following conditions. If you have any questions, please contact Clear Spring Health at 1-877-364-4566 (TTY: 711) Hours: October 1st – March 31st, seven days a week, 8:00 a.m. – 8:00 p.m., and April 1st – September 30th, Monday through Friday, 8:00 a.m. – 8:00 p.m. (voicemail will be available on Saturday, Sunday, and federal holidays).

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)