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Chronic Condition Pre-Assessment Form

In order to enroll in a Chronic Condition Special Needs Plan, Medicare requires that your chronic condition be verified. To verify your eligibility, we need you to answer a few questions and we need your primary care provider's (or treating physician's) office to confirm your chronic condition. This is a two-part process:

1. Answer the questions below and complete the information requested on page two of this form so that we can have your provider verify your chronic condition.
2. Send the completed form along with your application.

To be completed by the Applicant or by Authorized Legal Representative

Name: _____

DOB: M M – D D – Y Y Y Y **Medicare ID (MBI/HICN):** _____

Clinical pre-qualify questions

(This is a pre-assessment, post verification by your provider will occur after you are enrolled in the plan.)

I. Diabetes Mellitus ("Yes" to 1 or 2 pre-qualifies the candidate.) Note: A pre-diabetes diagnosis does not qualify for this plan.

1. Have you ever been told by a doctor or clinic that you have diabetes (too much sugar in the blood or urine)? ☐ Yes ☐ No ☐ Not sure
2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? ☐ Yes ☐ No ☐ Not sure

II. Chronic Heart Failure *("Yes" to question 1 or questions 2 and 3 pre-qualifies the candidate."Yes" to question 2 or 3 does not qualify the consumer and the application may require further verification.)*

1. Have you ever been told by a doctor or clinic that you have Congestive Heart Failure? ☐ Yes ☐ No ☐ Not sure
2. Have you had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem? ☐ Yes ☐ No ☐ Not sure
3. During the past 12 months, have you been counseled or educated by a health care professional about weighing yourself daily to monitor a heart problem? ☐ Yes ☐ No ☐ Not sure

III. Cardiovascular Disorders *("Yes" to any of the questions (1–6) pre-qualifies the candidate.)*

1. Have you ever been told by a doctor or clinic that you have a cardiovascular disorder such as atrial fibrillation (AFib), have an irregular or abnormal heartbeat, angina, or coronary artery disease? ☐ Yes ☐ No ☐ Not sure
2. Have you ever been told you have peripheral vascular disease, poor circulation or claudication in your legs? ☐ Yes ☐ No ☐ Not sure
3. Do you have chronic skin ulcers or vein problems in your legs? ☐ Yes ☐ No ☐ Not sure
4. Have you ever been prescribed medications to thin your blood like Warfarin or Clopidogrel for a heart condition? ☐ Yes ☐ No ☐ Not sure
5. Do you have a pacemaker or internal defibrillator? ☐ Yes ☐ No ☐ Not sure
6. Have you had angioplasty, stents or bypass on your heart or legs? ☐ Yes ☐ No ☐ Not sure

Applicant/Authorized Representative: _____

Completing this assessment does not guarantee enrollment in the plan. All Chronic Special Needs Plans require verification from a provider or specialist for enrollment.

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Chronic Condition Release of Information Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

Use and Disclosure Authorization

APPLICANT, please complete (* indicates required field).

I, *(insert applicant name)* _____ , hereby authorize the disclosure of my health information described above by:

Name of Provider (Last Name, First Name)*	Provider Telephone Number*
Provider Address*	
City*	State* / ZIP Code*

Applicant Date of Birth: MM – DD – YYYY

Applicant/Authorized Representative Signature _____ **Today's Date** MM – DD – YYYY

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Primary Care Provider/Specialist/Care Provider Representative), hereby certify that _____ (Applicant) has the following health condition(s):

☐ Diabetes Mellitus (Pre-diabetes excluded)

☐ Chronic Heart Failure ☐ Cardiovascular Disorders

Primary Care Provider/Treating Physician/Specialist Signature _____ **Today's Date** MM – DD – YYYY

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Please send the completed forms along with your application to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Or fax to:
1-888-950-1170

If you have any questions, please call:
1-855-548-1564, TTY **711**, 8 a.m. – 8 p.m. local time, 7 days a week

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