Chronic Condition Pre-assessment Form

To enroll in a Chronic Special Needs plan, Medicare requires that your chronic condition be verified by your treating physician's office.

Please answer the questions below and complete the information requested on the following page so we may have your treating physician verify your chronic condition.

Clinical pre-qualify questions

This is a pre-assessment. Post-verification by your treating physician will occur after you are enrolled in the plan.

Please answer these questions:

I. Diabetes mellitus (Note: A pre-diabetes diagnosis does not qualify for this plan.)

1. Has a doctor or clinic told you that you have diabetes (too much sugar in the blood or urine or high sugar(s))? ☐ Yes ☐ No
2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? ☐ Yes ☐ No

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II. Chronic heart failure

1. Has a doctor or clinic told you that you have chronic or congestive heart failure (fluid or water in the lungs or heart)? ☐ Yes ☐ No
2. Have you previously experienced fluid in your lungs, leg swelling and shortness of breath due to a heart problem? ☐ Yes ☐ No
3. In the past year, have you been advised by a health care professional to weigh yourself daily for heart monitoring? ☐ Yes ☐ No

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III. Cardiovascular disorders

1. Have you been diagnosed with an irregular heart rate (like atrial fibrillation), heart disease or coronary artery disease? ☐ Yes ☐ No
2. Have you been told you have peripheral vascular disease, poor circulation or claudication in your legs? ☐ Yes ☐ No
3. Do you have chronic skin ulcers or leg vein problems? ☐ Yes ☐ No
4. Have you been prescribed blood thinners like warfarin or clopidogrel for a heart condition? ☐ Yes ☐ No
5. Do you have a pacemaker or internal defibrillator? ☐ Yes ☐ No
6. Have you had an angioplasty, stents or bypass surgery on your heart or legs? ☐ Yes ☐ No

Completing this pre-assessment does not guarantee enrollment in the plan. All Chronic Special Needs plans require verification from a treating physician to be enrolled in the plan.

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. After you complete this form, please return it with your plan enrollment form. Do **not** take this form to your treating physician.

Treating physician information:

Full name:

Phone number:

Address:

City:	State:	ZIP code:

Fax number:

Email address:

National Provider Identifier (NPI) number (10–12 digits without dashes):

If you don't have all of this information, you can complete your treating physician's full name and NPI number (exactly as found in the Provider Directory or online).

Have you seen this provider within the last 2 years? ☐ Yes ☐ No