



Verification Form - Special Supplement Benefit for Chronically Ill (SSBCI)

CHPW offers a Special Supplement Benefit for Chronically Ill (SSBCI) to eligible Dual Complete (HMO D-SNP) members. To qualify, members must have one or more of the chronic conditions listed below.

Please verify the member's self-reported condition(s) by phone (866-418-7005), fax (206-652-7073), or email at medicarecm@chpw.org.

FIRST Name:	LAST Name:	Middle Initial (optional):
<input type="text"/>	<input type="text"/>	<input type="text"/>

Medicare ID Number (MBI):	Birth Date (MM/DD/YYYY):	Phone Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Your patient reports treatment for the following condition(s). To verify by fax or email, complete and return the form below.

- | | | |
|---|--|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Chronic heart failure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cancer (excluding pre-cancer conditions or in-situ status) | <input type="checkbox"/> Chronic lung disorders | <input type="checkbox"/> Neurologic disorders |
| <input type="checkbox"/> Cardiovascular disorders | <input type="checkbox"/> Dementia | <input type="checkbox"/> Severe hematologic disorders |
| <input type="checkbox"/> Chronic alcohol and other drug dependence | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic and disabling mental health conditions | <input type="checkbox"/> End-stage liver disease, requiring dialysis | |
| | <input type="checkbox"/> End-stage renal disease (ESRD) | |

FOR USE BY MEMBER'S HEALTHCARE PROVIDER TO VERIFY CHRONIC CONDITION(S)

Please check yes or no to indicate whether the patient has the condition(s) reported above:

- Yes** – This patient has one or more of the conditions indicated above.
- No** – We have no records confirming the patient has any of the indicated conditions above.

PROVIDER DETAILS (Full name, address, and phone number required to verify eligibility*)

Provider First and Last Name*:	Clinic Name:
<input type="text"/>	<input type="text"/>

Address*:	City:	ZIP:	State:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Phone*:	Fax
<input type="text"/>	<input type="text"/>

Provider Signature:	Today's Date (MM/DD/YYYY):
<input type="text"/>	<input type="text"/>