

Verification of Chronic Condition Form



Provider Name: _____

One of your patients has elected to enroll in a Champion Health Plan Special Needs Plan (C-SNP). To qualify for continued enrollment in this plan, CMS requires verification that the individual has been diagnosed with one or more of the plans qualifying chronic conditions.

Please complete a verbal or written verification within 10 days of receipt.

Phone: **1-800-514-6355** or Fax: **1-562-647-5764**

Patient Information

Last Name:	First Name:	M.I.
Medicare ID (MBI):	Date of Birth (mm/dd/yyyy):	

Verify the patient's qualifying conditions (check all that apply)

<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> End-stage renal disease (ESRD) requiring dialysis
<input type="checkbox"/> Chronic Heart Failure	<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> Cardiovascular disorders limited to: cardiac arrhythmia, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder	<input type="checkbox"/> Mental health conditions limited to: bipolar disorder, major depressive disorder, paranoid disorder, schizophrenia and schizoaffective disorder
<input type="checkbox"/> Patient does not have any of the above chronic conditions documented in his or her chart.	
Health Care Provider Attestation (the treating clinician authorized to diagnose the individual) I hereby attest that the above information is correct and noted in the patient's medical record.	
Printed Name:	Title:
Signature:	

CHAMPION HEALTH PLAN OFFICE ONLY

Date Received:	Champion Health Plan Associate:	Status:
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Champion Health Plan is an HMO, HMO POS, HMO C-SNP, with a Medicare contract. Enrollment in Champion Health Plan depends on contract renewal. Champion Health Plan complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability or sex.