

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. We also need this information to verify that you qualify for the healthy food benefit.

Please answer the questions below and complete the information requested on the following pages so we may have your treating physician verify your chronic condition. After you complete this form, please return it with your plan enrollment form. Do **not** take this form to your treating physician.

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

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

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 for enrollment in the plan.

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 this information, you can provide your treating physician's full name and NPI number (exactly as it's found in the Provider Directory or online).

Have you seen this provider within the last 2 years?

☐ Yes ☐ No

Authorization to release information

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

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers or health insurance companies and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not sign this form. However, if I do not sign this form, UnitedHealthcare may not be able to get information needed and may not be able to use another source to verify that I qualify for the healthy food benefit, and I may not be able to receive this benefit unless eligibility can be verified through another source. Also, I may not be able to exchange certain health information with my network providers, my previous health insurance company, or third parties named herein to better coordinate my healthcare and coverage;
- Once my health information is shared, the person or organization receiving it may share it again. If they are not a health plan, health insurance company or health care provider, the information may no longer be protected by federal privacy laws; and
- This authorization will expire 2 years from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing, by updating my consent-sharing preference on the member site or by calling Customer Service; however, the revocation will not influence any actions taken before the date my revocation is received and processed or any action taken pursuant to reliance on the authorization before the revocation became effective.

Who may receive and disclose my information:

I authorize UnitedHealthcare and its subsidiaries and affiliates to receive from or disclose my individually identifiable health information between and among themselves, my health care providers, my previous health insurance companies, and with vendors that help assess eligibility for benefits and services such as healthy food.

If I haven't already provided my previous health insurance company's name and my member number, I can submit it on the member site.

Type of information to be disclosed:

I authorize disclosure of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.

Purpose of disclosure:

My health information is being disclosed to:

- Verify that I qualify for the healthy food benefit or to verify my diagnosis of a covered chronic condition
- Help keep my health records complete and support my care by:
 - Requesting and sharing information with other health insurance companies I may have coverage with
 - Requesting health information from my previous health insurance company
 - Sharing health information with my network health care providers so they can work together on my care

Applicant signature**Date**

Witness signature (For Illinois residents only)**Date**

Please note: If you are a guardian or court appointed representative, please complete the Guardian or Representative fields and attach a copy of your legal authorization to represent the member.

Guardian or Representative

Name

Phone number

Street address

City

State

ZIP code

Guardian or Representative signature

Date

For California and Georgia residents only: I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

The healthy food benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, who also meet plan criteria indicating they are at high risk for hospitalization and eligible for intensive care coordination. Contact us for details.