



Chronic Conditions Special Needs Plan (CSNP) Pre-Qualification Form

CommuniCare Advantage Chronic Condition Special Needs Plan (CSNP) is a type of Medicare Advantage coordinated plan that is tailored to focus benefits and services to better meet the health care needs of individuals with certain chronic conditions.

You may be eligible to join our CSNP if you can answer YES to any of the questions below. CommuniCare Advantage will need to obtain verification of your chronic condition from your provider's office within 30 days of enrollment. If we are unable to receive verification of your chronic condition from your provider, we are required to disenroll you from the Chronic Conditions Special Needs Plan.

Therefore, it is important to provide your provider's name and contact information below. It would also be helpful if you would let your provider's office know that we will be contacting them to obtain their verification.

Beneficiary Information:

Beneficiary's Name: _____

Beneficiary's Signature: _____ Date: _____

CHF/CVD/Diabetes

Has your primary care provider or other licensed health care professional diagnosed you with any of the following medical conditions? (Check all that apply):

Congestive Heart Failure (CHF) Yes No **Cardiovascular Disease (CVD)** Yes No **Diabetes** Yes No

CHF:

Do you have fluid in your lungs? Yes No

Do you have swelling in your feet and legs almost every day because of too much fluid in your body? Yes No

Do you take medication for fluids in your lungs or to help your heartbeat stronger? Yes No

CVD:

Have you had a heart attack or been told by your doctor you are at risk of having one? Yes No

Do you have heart pain (Angina) or leg pain (Claudication) brought on when you are active? Yes No

Do you take medication for your heart or circulation? Yes No

Diabetes:

Do you check your blood sugar at home? Yes No

Do you have high blood sugar? Yes No

Do you take medicine to control your blood sugar? Yes No

Doctor/Healthcare Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name: _____ FIRST Name: _____

Telephone #: _____ Fax #: _____