CHRONIC CONDITION VERIFICATION FORM

The following member enrolled in a multi-condition Special Needs Plan. The Centers for Medicare and Medicaid Services (CMS) requires confirmation of the member's diagnosis from a current treating provider. Without confirmation, the member will be disenrolled from the plan.

Member Name:	DOB:
Enrollment start date:	Member ID:

I hereby certify that the above applicant has the following health condition(s):

- ☐ Diabetes
- ☐ Cardiac Arrhythmia
- ☐ Heart Failure
- ☐ Coronary Artery disease
- ☐ Peripheral Vascular disease
- ☐ Chronic Venous Thromboembolic disorder
- ☐ Does not have a qualifying condition
- ☐ Not an established patient

Provider Name:	Provider NPI:
Provider Phone Number:	Provider Fax Number:
Provider Signature:	
Date:	Provider Credentials: ☐ MD ☐ NP ☐ PA

If the treating provider is different from the provider listed above:

Provider Signature:	
Provider Printed Name or Stamp:	
Date:	Provider Credentials: ☐ MD ☐ NP ☐ PA
Provider Phone Number: ( ) -	Provider Fax Number: ( ) -

Fax this form to:
(562) 308-3679

Email to:
C-SNPDXVerification@SCANHealthPlan.com

For questions or to provide verification prior to enrollment start date, please call:
(877) 778-7226, option 6, 8 a.m. – 5 p.m. PST, Monday – Friday.