Provider Verification of Chronic Condition

Enrollee: Please complete section 1 and then give this form to your provider. (Note: Provider can also complete section 1 on behalf of the enrollee).

Provider: The individual below has enrolled in the HAP Medicare Chronic Condition Special Needs Plan (C-SNP) based on their diabetes mellitus, CHF or cardiovascular condition. The Centers for Medicare and Medicaid Services (CMS) requires the healthcare provider verify that the C-SNP enrollee has been diagnosed with one or more of these chronic conditions. Without this verification, the enrollee will be disenrolled from the plan.

Please print this form and complete all the fields below. Send signed, completed form via fax or secure email as soon as possible. For questions, please contact the CSNP Case Management team at (800) 288-2902.

Fax: (313) 664-5959 **Secure Email: CSNPVerification@hap.org**

Section 1. Enrollee demographic information **ALL FIELDS MUST BE COMPLETED**	
Enrollee full name:	
Date of birth (MM/DD/YYYY):	Medicare ID number:
Enrollee phone number: ( )	HAP member ID (if available):

Section 2. Condition verification **ALL FIELDS MUST BE COMPLETED & FORM MUST BE SIGNED.**

Please select the applicable box for the enrollee's chronic conditions, sign and enter title/office phone number. By signing this form, you attest the enrollee has a diagnosis of one or more of the chronic conditions below.

Diabetes Mellitus (DM)	Chronic Heart Failure (CHF)	Cardiovascular Disorder:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No If yes, check all that apply: ☐ Cardiac Arrhythmias ☐ Coronary Artery Disease ☐ Peripheral Vascular Disease ☐ Chronic Venous Thromboembolic Disorder

☐ Enrollee does not have any of the above chronic conditions ☐ Enrollee is not under my care

Office phone number: ( )	Office fax number: ( )
Physician/Nurse Practitioner/Physician Assistant name:	
NPI*:	Tax ID No.*:
Physician/Nurse Practitioner/Physician Assistant Signature	Date

*Required for potential incentive payment.