



Chronic Special Needs Plan (CSNP) Pre-Qualification Form

Ultimate Health Plans offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions: Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), and Chronic Lung Disorder/COPD, Diabetes Mellitus (DM). You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. We will verify the presence of the chronic condition with your health care provider within 30 days of enrollment. We are required to disenroll you from the special needs plan if we cannot verify your chronic condition. Therefore, please let your doctor know that we will require their verification of the information below. Please provide us with accurate contact information for your doctor or other health care provider on this form.

Do You Have a Chronic Condition?

Has your doctor or other licensed healthcare professional diagnosed you with any of the following medical conditions? (Check all that apply)

Cardiovascular Disease (CVD): Yes No
Chronic Lung Disorder/COPD: Yes No

Chronic Heart Failure (CHF): Yes No
Diabetes Mellitus (DM): Yes No

Cardiovascular Disease (CVD) Plans 021, 026, 029, 033, 050, 051, 052

1. Have you had or been told you're at risk of having a heart attack? Yes No
2. Have you received a stent in your heart? Yes No
3. Do you have a pacemaker, or do you take any medications for abnormal heart rhythm? Yes No
4. Has your doctor told you that you have reduced blood flow to your legs or feet? Yes No
5. Have you ever had a procedure to improve blood supply to your legs or feet? Yes No
6. Have you been diagnosed with abnormal heart sounds (murmur), leaky or very tight valves, or have you had surgery to replace valves? Yes No

Chronic Heart Failure (CHF) Plans 021, 026, 029, 033, 050, 051, 052

1. Has your doctor told you that your heart is not pumping as well as it should? Yes No
2. Do you have swelling in your feet and legs almost every day due to too much fluid in your body? Yes No
3. Do you take a water pill due to a heart-related condition (such as heart failure)? Yes No
4. Do you take medication for the fluid in your lungs or to help your heart beat stronger? Yes No

Chronic Lung Disorder/COPD Plans 023, 025

1. Do you suffer from breathing problems due to lung disease (emphysema, chronic bronchitis, asthma, or fibrosis of lungs)? Yes No
2. Has your doctor told you that you have permanent lung damage due to smoking or inhalation of toxins? Yes No
3. Has your doctor prescribed you any medications (such as a breathing pump, steroids) or extra oxygen to help you breathe better? Yes No

Diabetes Mellitus (DM) Plans 021, 026, 029, 033, 050, 051, 052

1. Do you regularly check your blood sugar at home? Yes No
2. Have you been diagnosed with high blood sugar (diabetes)? Yes No
3. Do you take any medications to control your blood sugar? Yes No

Health Care Provider Contact Information

PROVIDER LAST NAME:

PROVIDER FIRST NAME:

PHONE NUMBER:
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FAX NUMBER:
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Beneficiary Information

LAST NAME:

FIRST NAME: MI:

SIGNATURE:

TODAY'S DATE: (MM/DD/YYYY)
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