Chronic Special Needs Plan (CSNP) Qualification Verification Form

ULTIMATE HEALTH PLANS

Urgent Action Required

LAST NAME: FIRST NAME:

MEDICARE NUMBER: DATE OF BIRTH: *(MM/DD/YYYY)* PLAN NUMBER: H2962 -

In order to confirm you have the qualifying condition(s) to enroll in our Chronic Special Needs Plan (CSNP), please visit your physician and have them complete the information below.

Please fax to **855-825-8128 or email at SNP@ulthp.com.**
You may also mail it to **Ultimate Health Plans Enrollment** at **PO Box 3459, Spring Hill, FL 34611**.
A copy of this letter was also faxed to your physician.

To Be Completed by Physicians, Physician's Extenders, Allied Health Providers, and Nurses.

The above applicant has applied to enroll in the Chronic Special Needs Plan offered by their health plan. To qualify for this Plan, the applicant must have one of the following conditions. If you have any questions, please contact Ultimate Health Plans at 1-888-657-4170, Monday through Friday from 8:00 am - 8:00 pm. During certain parts of the year, we may use alternative technologies to answer your call on weekends and Federal holidays. TTY users can call 711.

We request you to confirm that the applicant has one of the qualifying conditions by placing a checkmark in the appropriate box(s).

- ❒ **Cardiovascular Disease (CVD)** – *Plans 021, 026, 029, 033, 050, 051, 052*
  Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease
- ❒ **Chronic Heart Failure (CHF)** – *Plans 021, 026, 029, 033, 050, 051, 052*
- ❒ **Chronic Lung Disorder/COPD** – *Plans 023, 025*
  Asthma, Chronic Bronchitis, Cystic Fibrosis, Emphysema, Pulmonary Fibrosis, Pulmonary Hypertension
- ❒ **Diabetes Mellitus (DM)** – *Plans 021, 026, 029, 033, 050, 051, 052*
  -OR-
- ❒ I **DO NOT** confirm the presence of any condition listed above.

PHYSICIAN LAST NAME: PHYSICIAN FIRST NAME:

AUTHORIZED SIGNATURE: TODAY'S DATE: *(MM/DD/YYYY)*

Must be signed by the physician's office.