# Chronic Condition Verification Form for Special Supplemental Benefits for the Chronically Ill (SSBCI)

**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 receive the additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI) on your plan, please visit your physician and have them complete the information below. If you have any questions, please contact Ultimate Health Plans at 888-657-4170 (TTY 711), Monday through Friday from 8:00 am to 8:00 pm. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

Please fax to **855-825-8128 or email to 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 member has enrolled in a plan that offers additional benefits as part of the Special Supplemental Benefits for the Chronically Ill on their plan. To qualify, the member must have one of the following conditions.
We request you to confirm that the member has one of the qualifying conditions by placing a checkmark in the appropriate box(s).

- ❒ Chronic alcohol use disorder and other substance use disorders (SUDs)
- ❒ Autoimmune disorders
- ❒ Cancer
- ❒ Cardiovascular disorders
- ❒ Chronic heart failure
- ❒ Dementia
- ❒ Diabetes mellitus
- ❒ Overweight, obesity, and metabolic syndrome
- ❒ Chronic gastrointestinal disease
- ❒ Chronic kidney disease (CKD)
- ❒ Severe hematologic disorders
- ❒ HIV/AIDS
- ❒ Chronic lung disorders
- ❒ Chronic and disabling mental health conditions
- ❒ Neurologic disorders
- ❒ Stroke
- ❒ Post-organ transplantation
- ❒ Immunodeficiency and Immunosuppressive disorders
- ❒ Conditions associated with cognitive impairment
- ❒ Conditions with functional challenges
- ❒ Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- ❒ Conditions that require continued therapy services in order for individuals to maintain or retain functioning

**-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.***