



Special Supplemental Benefits for the Chronically Ill Attestation

To be eligible to receive the additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI) on your plan, you must have at least one chronic health condition listed on this form and meet all three requirements below. Check each condition your doctor has diagnosed.

You must:

1. Have one or more serious and complex long-term health conditions that are life-threatening or greatly limit your health or daily activities.
2. Be at high risk of going to the hospital or having another serious health problem.
3. Need a high level of help coordinating care among your doctors and health care services.

To begin receiving your benefits, your physician must complete and return the SSBCI Qualification Verification Form, so please provide accurate contact information for your doctor or other health care provider on this form.

Once confirmed, your benefits will be available on your Ultimate Benefit Card within seven business days.

Do You Have a Chronic Condition?

I have been diagnosed by my doctor with the following chronic health condition(s). *(Check all that apply)*

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

Health Care Provider Contact Information

PROVIDER LAST NAME:

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PROVIDER FIRST NAME:

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PHONE NUMBER:

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FAX NUMBER:

(			)																
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Beneficiary Information

LAST NAME:

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SIGNATURE: |

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

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