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Aetna® Medicare Prequalification Assessment Tool

IMPORTANT: You are enrolling in an Aetna Medicare Advantage Chronic Condition Special Needs Plan (C-SNP). Our C-SNP plans are for people who have diabetes, congestive heart failure and certain cardiovascular diseases. To be a member, the Centers for Medicare & Medicaid Services (CMS) requires us to confirm with your provider that you have one of these conditions. **This is a two-step process.**

Step 1: Please fill out this form. Return it with your completed enrollment application. If you can check the box to at least one condition, you may qualify for an Aetna C-SNP plan.
Step 2: We will confirm your condition within 30 days of your enrollment with your provider.

Read the following statements carefully and check the box that applies to you.

By checking a box, you certify that, to the best of your knowledge, you have one of the covered chronic conditions to join this type of plan. If we later determine that this information is incorrect, you may be disenrolled.

Applicant's chronic condition diagnosis — at least one box below must be checked.

Has a provider ever diagnosed you with one or more of the following conditions?

☐ **Diabetes Mellitus** (High Blood Sugar):	☐ **Chronic Heart Failure (CHF)** (Enlarged heart and/or fluid on the lungs):	**Cardiovascular disease:** ☐ Cardiac Arrhythmias (Irregular Heartbeat) ☐ Coronary Artery Disease (Heart Blockages) ☐ Peripheral Vascular Disease (Poor circulation in your legs/feet and/or arms/hands) ☐ Chronic Venous Thromboembolic Disorder (Blood Clots in your legs or lungs)
☐ **I do not have any of these conditions.**		

Use and disclosure authorization.

Completion of this form authorizes the disclosure of individually identifiable health information in accordance with federal laws concerning the privacy of such information.

By providing your signature below, you certify that you have been diagnosed with one or more of the chronic conditions necessary for enrollment in an Aetna Medicare Chronic Condition Special Needs Plan and authorize the provider listed below to confirm this diagnosis so that Aetna Medicare can confirm for C-SNP enrollment.

Applicant/Authorized Representative — Please complete all fields as applicable.	
Applicant name (Required):	Date of birth (Required):
Medicare number (Required):	Phone number (Required): (_____) _____- _____
Signature (Required):	Today's date:

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If you are an authorized representative helping someone to fill out this form, you must sign above and provide the following information.

Name:	Relationship to applicant:
Address:	Phone number: (_____) _____- _____

Provider #1 who can verify your chronic condition — (Required)

Physician/Nurse Practitioner/Physician Assistant name:

Office phone number: (_____) _____- _____	Office fax number (optional): (_____) _____- _____

Address line 1:

Address line 2:

City:	State:	ZIP code:

Office email address (if available):

Provider #2 who can verify your chronic condition — (Optional)

Physician/Nurse Practitioner/Physician Assistant name:

Office phone number: (_____) _____- _____	Office fax number: (_____) _____- _____

Address line 1:

Address line 2:

City:	State:	ZIP code:

Office email address (if available):