Select Health Medicare Grocery Benefit Chronic Condition Attestation Form

To be eligible to receive the grocery benefit provided with a Select Health Medicare plan, you must have a qualifying chronic condition.

You must attest that you have at least one of the listed health conditions by completing this form and signing below. Select Health must verify your chronic condition before you are given access to the grocery benefit. You will still be able to use the over-the-counter allowance.

FIRST Name	MIDDLE Initial (optional)	LAST Name
Medicare ID Number (MBI)	Birth Date _____ /_____ /_____ (MM / DD / YYYY)	Phone Number ( )

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

- ❑ Autoimmune disorders
- ❑ Cancer
- ❑ Chronic alcohol and other drug dependence
- ❑ Chronic and disabling mental health conditions
- ❑ Chronic heart failure
- ❑ Chronic liver/Kidney disease
- ❑ Chronic lung disorders
- ❑ Dementia
- ❑ Diabetes
- ❑ End-stage liver disease
- ❑ End-stage renal disease (ESRD)
- ❑ HIV/AIDS
- ❑ Hypertension
- ❑ Malnutrition
- ❑ Musculoskeletal disorders
- ❑ Neurologic disorders
- ❑ Obesity
- ❑ Severe hematologic disorders
- ❑ Stroke

❑ I do NOT have any of the above chronic conditions

HEALTHCARE DOCTOR(S) WHO CAN VERIFY YOUR CHRONIC CONDITION(S)

DOCTOR #1 (Required)

Doctor Name: _____

Doctor Address: _____

Doctor Phone: _____ Doctor Fax: _____

DOCTOR #2 (Optional)

Doctor Name: _____

Doctor Address: _____

Doctor Phone: _____ Doctor Fax: _____

Enrollee Signature:	Today's Date _____ /_____ /_____ (MM / DD / YYYY)

Please fax the completed form to **855-442-0357** or mail it to the address below.

ATTN: SELECT HEALTH MEDICARE ENROLLMENT
P.O. Box 30196
Salt Lake City, UT 84130-0196

Select Health will verify your chronic condition with your doctor for access to the Select Health Medicare grocery benefit. If we are unable to verify your chronic condition(s), we will restrict the use of the grocery benefit. If your chronic condition needs to be verified again in the future, you will be issued a new verification form.

I hereby authorize the disclosure of my health information by the doctors listed above to Select Health in order to verify that I have been diagnosed with a chronic condition, which qualifies me to utilize specific benefits provided with a Select Health Medicare plan. This authorization applies to all health information maintained by the doctor concerning my medical history for the chronic condition(s) indicated above. I may refuse to sign or may revoke this authorization at any time for any reason, unless Select Health has already made disclosures in reliance on this authorization.

Note: Information disclosed as a result of this authorization will be protected by Select Health in accordance with applicable state and federal laws and requirements. A legal representative may help you complete this verification form. If a legal representative helps you complete this form and signs on your behalf, please include a description of the representative's authority.

For more information or for assistance with this form, please call us at **855-442-9900 (TTY: 711)**.

October 1 to March 31: Weekdays 8:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
April 1 to September 30: Weekdays 8:00 a.m. to 8:00 p.m., closed weekends.

Select Health is an HMO, PPO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Advantage depends on contract renewal.

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

Select Health Medicare **1-855-442-9900 (TTY: 711)** / Select Health: **1-800-538-8038**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電