Select Health Medicare Grocery Benefit Chronic Condition Verification Form

One of your patients has elected to enroll in a Select Health Medicare plan with a grocery benefit. This allows the member to buy groceries and healthy items using their Select Health Medicare Flexible Benefits card. To qualify for this benefit, CMS requires verification from a healthcare provider that the individual has been diagnosed with one or more qualifying chronic conditions.

Please provide verbal or written verification within 48 hours of receipt by:

Phone: Call **855-442-9876** weekdays, from 8:00 a.m. to 5:00 p.m. Mountain Time (MST).

Fax: Send your completed and signed form to **801-442-0357.**

PROVIDER INFORMATION		
LAST Name	FIRST Name	
PATIENT INFORMATION		
LAST Name	FIRST Name	MI
Medicare ID Number (MBI):	Birth Date _____/_____/_____ (MM / DD / YYYY)	

PLEASE VERIFY THE PATIENT'S QUALIFYING CHRONIC CONDITIONS (CHECK ALL THAT APPLY)

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

❑ Patient does NOT have any of the above chronic conditions documented in his or her chart.

HEALTHCARE PROVIDER ATTESTATION (CAN BE COMPLETED BY PROVIDER OR OFFICE STAFF)

I HEREBY ATTEST THAT THE ABOVE INFORMATION IS CORRECT AND NOTED IN THE PATIENT'S MEDICAL RECORD.

Printed Name_____ Title_____

Signature_____ Today's Date_____/_____/_____

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