



Select Health

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. For a full list of qualifying chronic conditions please visit selecthealth.org/medicare/kroger-grocery.

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		
Provider 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)		
<input type="checkbox"/> Autoimmune disorders	<input type="checkbox"/> Chronic lung disorders	<input type="checkbox"/> Malnutrition
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dementia	<input type="checkbox"/> Musculoskeletal disorders
<input type="checkbox"/> Cardiovascular disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurologic disorders
<input type="checkbox"/> Chronic alcohol and other drug dependence	<input type="checkbox"/> End-stage liver disease	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic and disabling mental health conditions	<input type="checkbox"/> End-stage renal disease (ESRD)	<input type="checkbox"/> Severe hematologic disorders
<input type="checkbox"/> Chronic heart failure	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chronic liver/Kidney disease	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> 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.