GOLD KIDNEY HEALTH PLAN

CONDITION VERIFICATION

PRE-ENROLLMENT FORM

Complete this form if enrolling in a Gold Kidney Health Plan Chronic Condition Special Needs Plan

Gold Kidney of Arizona Medicare Advantage Special Need Plans offers coverage for individuals with cardiovascular disorders, chronic heart failure, kidney diseases or diabetes.

Please complete this form and return it to us with your completed enrollment application. If you have been diagnosed by your doctor or receive treatment for least one of the chronic conditions noted above qualify for enrollment in a C-SNP offered by Gold Kidney Health Plan.

We kindly request your permission to verify your condition with the doctor(s) or clinic(s) information you provide below. This information will be used to verify your chronic condition within two months of your enrollment. Medicare requires Gold Kidney Health Plan to verify your chronic condition as part of the enrollment process. If we are unable to verify your chronic condition, we must disenroll you from the C-SNP.

Applicant Information		
LAST Name	FIRST Name	Middle Initial (Optional)
Birthdate (MM/DD/YYY) __ __ / __ __ / __ __ __ __	Medical Number __ __ __ __ - __ __ __ - __ __ __ __	
Phone Number		
Alternate Phone Number		

GOLD KIDNEY HEALTH PLAN

Health care provider(s) who can verify your chronic condition(s)	
Provider #1 Name	Provider #1 Phone Number
Provider #1 Address/Location	
Provider #2 Name	Provider #2 Phone Number
Provider #2 Address/Location	
Provider #3 Name	Provider #3 Phone Number
Provider #3 Address/Location	

Authorization for use and disclosure of health information for chronic condition(s) health plan eligibility

I authorize the providers listed above to disclose my health information to Gold Kidney Health Plan to verify I have been diagnosed with a chronic condition that qualifies me for enrollment into a Gold Kidney Health Plan Chronic Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the qualifying chronic conditions indicated in this form.

Note: Completion of this document authorizes the disclosure and/or use of individually identifiable health information, consistent with state and federal law concerning the privacy of such information.

Applicant Name (printed): _____

Signature: _____ Date: _____