GOLD KIDNEY HEALTH PLAN

Gold Kidney Health Plan (HMO C-SNP)
Chronic Condition Verification Form

Provider Name:		
One of your patients has elected to enroll in a Gold Kidney Medicare Advantage Chronic Special Needs Plan (C-SNP). To qualify for continued enrollment in this plan, CMS requires verification from a healthcare provider that the individual has been diagnosed with one or more of the plan-qualifying chronic conditions.		
Patient Information		
Last Name:	**First Name:**	**MI:**
Medicare ID (MBI):	**Date of birth:** _____ / _____ / _____	
Please verify the patient's qualifying conditions (check all that apply)		
☐ Cardiovascular Disorders ☐ Diabetes ☐ Chronic Heart Failure ☐ 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:	**Date:** _____ / _____ / _____	

Please complete verbal or written verification within 48 hours of receipt. You or your office staff may complete this verification by:

Phone: To provide verbal verification, please contact Gold Kidney Members Services at **(844) 294-6535 (TTY: 711).** We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m. local time, 7 days a week (except holidays), and April 1 through September 30 from 8:00 a.m. to 8:00 p.m. local time, Monday through Friday (except holidays).

Fax: To provide written verification, please fax the completed and signed verification form to **(866) 547-1920.**

Gold Kidney office use only		
Date received:	**Gold Kidney Rep.:**	**Status:**

Gold Kidney Health Plan, Inc., is an HMO-POS and HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.