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

Provider Name:				
One of your patients has elected Special Needs Plan (C-SNP). To verification from a healthcare prof the plan-qualifying chronic co	qualify for continued ovider that the indivi	l enrollment	in this plan, CMS	requires
Patient Information				
Last Name:	First Name:			MI:
Medicare ID (MBI):		Date of bir	th: //	
Please verify the patient's qualifying conditions (check all that apply)				
 □ Cardiovascular Disorders □ Chronic Heart Failure □ Chronic Kidney Disease □ End-Stage Renal Disease (ESRD) □ 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 may complete this verification by: Phone: To provide verbal verification (844) 294-6535 (TTY: 711). We	cation, please contact e are available Octobe	Gold Kidne er 1 through	y Members Servic March 31 from 8:0	es at 00 a.m. to 8:00
p.m. local time, 7 days a week (e to 8:00 p.m. local time, Monday				from 8:00 a.m.
Fax: To provide written verificat (866) 547-1920.	ion, please fax the co	mpleted and	d signed verificatio	on form to
Gold Kidney office use only				
Date received:	Gold Kidney Rep.:		Status:	

Gold Kidney Health Plan, Inc. $^{\circledR}$, is an HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.