

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

<b>Provider Name:</b>		
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.		
<b>Patient Information</b>		
<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>
<b>Medicare ID (MBI):</b>	<b>Date of Birth:</b>	

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), ext. 5013. 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, fax the completed and signed verification form to (866) 547-1920.

Chronic Condition Verification			
Medicare requires Gold Kidney Health Plan to verify your chronic condition as part of the enrollment process. You must have a qualifying condition to enroll in a Gold Kidney health plan. If you are not seeing a physician today for one of the qualifying conditions in either Heart & Diabetes or Dialysis & Kidney sections below, you may not qualify for our plan. It is important for you to provide us with contact information for a doctor or clinic that can verify your condition. <b>Note:</b> If we are unable to verify your chronic condition, we <u>must</u> disenroll you from the C-SNP plan at the end of your second month of enrollment.			
<b>Qualifying for Gold Kidney Heart &amp; Diabetes Plans:</b> You must answer "yes" to at least one of the chronic condition questions below to qualify for any Gold Kidney heart & diabetes plan			
Have you been diagnosed by your doctor or other licensed healthcare professional with any of the following illnesses?			
Blood clots or vascular disease of the legs (CVD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary artery disease (CAD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes (sugar disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive heart failure (CHF)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Previous stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been prescribed or are you currently taking medication for an illness listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List doctors, clinics, and other healthcare providers who can verify your "Yes" answers.			
Provider #1 (Physician Name) (required)	Specialty	City	
Phone Number:		Fax Number:	

Provider #2 (Physician Name)	Specialty	City
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Phone Number:	Fax Number:
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**Release of Information**

Completion of this section authorizes the disclosure and use of individually identifiable information, as set forth below, consistent with Federal Law concerning the privacy of such information.

I herewith authorize and direct Gold Kidney to confirm my chronic conditions and obtain my medical records until I am no longer enrolled in the Gold Kidney Health Plan. **(Box must be checked for CSNP verification)**

Applicant Name (printed):	Date:
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Applicant/Authorized Representative Signature:	Physician Signature:
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**Qualifying for Gold Kidney Dialysis & Kidney Plans:** You must answer "yes" to at least one of the questions below to qualify for any Gold Kidney dialysis & kidney plan

Have you had a blood test showing that you have chronic kidney disease (CKD) at any stage 1-5?  Yes  No

If yes, please select the stage of CKD:  1  2  3  4  5  Not sure

If known, what is your eGFR? \_\_\_\_\_

Are you currently receiving regularly scheduled dialysis? (Either in-home or in-center)  Yes  No

Do you have end-stage renal disease (ESRD) / end-stage kidney disease (ESKD)?  Yes  No

Are you currently taking any of the following types of medications?

Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes (sugar disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

List doctors, clinics, and other healthcare providers who can verify your "Yes" answers.

Primary Nephrologist Name (required)	Phone Number	City
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Provider #1 (Physician Name)	Specialty	City
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Phone Number:	Fax Number:
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Provider #2 (Physician Name)	Specialty	City
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Phone Number:	Fax Number:
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Applicant Name (printed):

Date:

Applicant/Authorized Representative Signature:

Physician Signature:

**Gold Kidney Office Use Only**

Date Received:

Gold Kidney Representative:

Status:

Gold Kidney Health Plan, Inc.<sup>®</sup>, is an HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.