Chronic Condition Verification Form

Use and Disclosure Authorization

PRIMARY CARE PROVIDER/TREATING PHYSICIAN/SPECIALIST, please complete.

I,_____ (Primary Care Provider/Specialist/Care Provider Representative), hereby certify that _____ (Applicant) has the following health condition(s):

☐ **Diabetes Mellitus (Pre-diabetes excluded)** ☐ **Chronic Heart Failure**

☐ **Cardiovascular Disorders**

Primary Care Provider/Specialist Signature: _____ **Date:** MM–DD–YYYY

Provider Telephone Number ___–___–____

By signing below, Applicant authorizes Provider to disclose Applicant's health information (listed above) to UnitedHealthcare, so that UnitedHealthcare can determine Applicant's eligibility for C-SNP plan coverage.

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative	Medicare ID Number (MBI/HICN) or Date of Birth
Signature of Applicant/Authorized Representative	**Today's Date** MM–DD–YYYY

If you are the authorized representative of the applicant, please provide the following information:

Relationship to Applicant	Address	Telephone Number ___–___–____

Fax this form to:
1-888-950-1170

Mail this form to:
UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

If you have any questions, please call:
1-866-868-0615, TTY **711**, 8 a.m.–5 p.m. CT, Monday–Friday