Chronic condition verification form

This form authorizes the disclosure and/or use of individually identifiable health information, which is consistent with federal laws about the privacy of such information.

Use and disclosure authorization

Provider/Specialist/Representative

I, _____ (Provider/Specialist/Representative)

hereby certify that _____ (Applicant)

has the following health condition(s):

☐ Diabetes ☐ Chronic heart failure ☐ Cardiovascular disorders

Reason why no condition selected: ☐ Patient not seen
☐ No chronic condition

Provider/Specialist/Representative signature:	Date:

Member information

Member name:

Medicare ID number:	Date of birth:

Fax this form to: 877-389-1802

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