# SSBCI verification form

Use this Special Supplemental Benefits for the Chronically Ill (SSBCI) verification form to confirm that a Dual Eligible Special Needs Plan (D-SNP) member has been diagnosed with at least one of the qualifying chronic conditions listed below. This verification is required to determine the members' eligibility for healthy food and utility assistance benefits.

Fax this completed form to **877-389-1802**.

## Use and disclosure authorization

**To be completed by the primary care provider/treating physician/specialist**

I, _____

(primary care provider/specialist/care provider representative), hereby certify that

_____ (applicant) has the following health condition(s):

- ☐ Autoimmune disorders
- ☐ Cancer
- ☐ Cardiovascular disorders
- ☐ Chronic alcohol use disorder or other substance use disorders
- ☐ Chronic and disabling mental health conditions
- ☐ Chronic gastrointestinal disease
- ☐ Chronic heart failure
- ☐ Chronic kidney disease
- ☐ Chronic lung disorders
- ☐ Conditions associated with cognitive impairment (e.g., Alzheimer's disease, intellectual disability and developmental disabilities, traumatic brain injuries, disabling mental illness associated with cognitive impairment or mild cognitive impairment)
- ☐ Conditions with functional challenges (e.g., spinal cord injuries, paralysis, limb loss, stroke and arthritis) that may require similar services
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ HIV/AIDS
- ☐ Chronic hyperlipidemia
- ☐ Chronic hypertension
- ☐ Immunodeficiency or immunosuppressive disorders
- ☐ Myasthenia gravis/ myoneural disorders, Guillain-Barre Syndrome, or inflammatory/toxic neuropathy
- ☐ Neurologic disorders
- ☐ Overweight, obesity or metabolic syndrome
- ☐ Post-organ transplantation care
- ☐ Severe hematologic disorders
- ☐ Stroke

☐ **None;** please circle one: Patient not seen / No chronic conditions

**Signature of primary care provider/treating physician/specialist:**

| Date: | Phone: |
|---|---|

**Member information**

| Member name: | Medicare ID number (MBI/HICN): |
|---|---|
| Date of birth: | |




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