



Aetna® Medicare Prequalification Assessment Tool

IMPORTANT: You are enrolling in an Aetna Medicare Chronic Condition Special Needs Plan (C-SNP).

Our C-SNP is for people who have diabetes, congestive heart failure and certain cardiovascular disorders. Before we can enroll you in a C-SNP, we are required by the Centers for Medicare & Medicaid Services (CMS) to confirm with your provider that you have one of these conditions.

This is a two-step process.

Step 1: Please fill out this form. Return it with your completed enrollment application. If you check the box for at least one condition, you may qualify for an Aetna Medicare C-SNP.

Step 2: We will confirm your qualifying condition within 30 days of your enrollment with your physician.

Note: Without provider verification of chronic condition within 60 days of enrollment, you will be involuntarily disenrolled from the plan.

Read the following statements carefully and check the box of the condition that applies to you.

By checking a box, you certify that you have one of the covered chronic conditions required to join this type of plan. If we later determine that this information is incorrect, you may be disenrolled.

Applicant's chronic condition diagnosis (check at least one box below):

Has a provider ever diagnosed you with one or more of the following conditions?

☐ Diabetes (high blood sugar)	☐ Chronic heart failure (CHF) (heart is unable to pump blood as it should)	☐ Cardiovascular disease: ☐ Cardiac arrhythmias (irregular heartbeats) ☐ Coronary artery disease (blocked blood vessels in the heart) ☐ Peripheral vascular disease (poor circulation in the arms and legs) ☐ Valvular heart disease (damage of flaps in the heart that control blood flow)
☐ I do not have any of these conditions.		

Use and disclosure authorization

Completion of this form authorizes the disclosure of individually identifiable health information in accordance with federal laws concerning the privacy of such information.

By providing your signature below, you certify that you have been diagnosed with one or more of the chronic conditions necessary for enrollment in an Aetna Medicare Chronic Condition Special Needs Plan and authorize the provider(s) listed below to confirm this diagnosis so that Aetna Medicare can confirm your C-SNP enrollment.

Applicant/Authorized representative — please complete all fields as applicable.

Applicant name (required):	Date of birth (required): ___/___/_____
Medicare number (required): _____ - _____ - _____	Telephone number (required): (____) _____ - _____
Signature (required):	Today's date: ___/___/_____

If you are an authorized representative helping someone fill out this form, you must sign above and provide the information below.

Name:	Relationship to applicant:
Address:	Telephone number (required): (____) _____ - _____

Please provide the name of the provider(s) who can confirm your diagnosis below.

Provider #1 who can verify your chronic condition — (required)

Physician/Nurse practitioner/Physician assistant name (required):		
Office telephone number (required): (____) _____ - _____	Office fax number (optional): (____) _____ - _____	
Provider ID from the provider directory (if available for an in-network provider):	Primary care provider ID (if available for an in-network provider):	
Address line 1		
Address line 2		
City	State	ZIP code
Office email address (if available):		

Provider #2 who can verify your chronic condition (optional)

Physician/Nurse practitioner/Physician assistant name:		
Office telephone number: (____) ____ - ____	Office fax number: (optional) (____) ____ - ____	
Address line 1		
Address line 2		
City	State	ZIP code
Office email address (if available):		

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.