Provider Attestation of Patient Diagnosis for SSBCI Eligibility

Form Instructions

To qualify for SSBCI, your patient must be a chronically ill individual who has one or more of the four active qualifying chronic conditions listed on the next page and **meet all of the following**:

1) is life threatening or significantly limits the overall health or function of the individual;
2) has a high risk of hospitalization or other adverse health outcomes; and
3) requires intensive care coordination.

Eligibility for SSBCI cannot be guaranteed based solely on your patient's conditions. All applicable eligibility requirements must be met before the benefit is provided.

Please complete this **Provider Attestation of Patient Diagnosis for SSBCI Eligibility** attesting that the patient meets the above criteria and documenting the qualifying conditions the patient has been diagnosed with in the past 12 months. Then, **fax** the completed form to **413-733-1924 or mail it to**:

Commonwealth Care Alliance, Inc.
101 Wason Avenue, 3rd Floor
Springfield, MA 01107

ALL FIELDS MUST BE COMPLETED

Patient Information

First Name: _____ Last Name: _____ MI: ___

CCA Member ID: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Provider Attestation

☐ My records for the above-named patient document diagnoses of a chronically-ill individual who has one or more of the four active qualifying chronic conditions selected below and **meet all of the following**:

1) is life threatening or significantly limits the overall health or function of the individual;

2) has a high risk of hospitalization or other adverse health outcomes; and

3) requires intensive care coordination.

The active qualifying chronic conditions selected below apply:

☐ Cardiovascular disorders limited to:
- Cardiac arrhythmias
- Coronary artery disease
- Peripheral vascular disease
- Chronic venous thromboembolic disorder

☐ Chronic lung disorders:
- Asthma
- COPD
- Chronic bronchitis
- Emphysema
- Pulmonary fibrosis
- Pulmonary hypertension

☐ Chronic Heart Failure

☐ Diabetes

☐ **My records for this patient do not include a diagnosis of any of the above conditions and/or the patient is not at high risk of hospitalization or other adverse health outcomes**.

I hereby attest that the information selected above is correct and is noted in the patient's medical record.

_____	_____	_____
Provider Name (please print)	Provider Credential (i.e., MD, PCP)	Provider NPI#

_____ _____

Provider Signature Date

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____