Special Supplemental Benefits for the Chronically Ill (SSBCI) Provider Clinical Attestation

Purpose

Commonwealth Care Alliance® (CCA) may use this clinical information to determine whether a patient meets Medicare requirements for SSBCI. This verification is required to determine the members' eligibility for healthy food, utility and non-medical, non-emergent transportation benefits. To qualify, the patient must meet all of the following:

1. Have one or more active qualifying chronic conditions that are life threatening or significantly limit overall health or function;
2. Be at high risk of hospitalization or other adverse health outcomes;
3. Require intensive care coordination; and
4. Have a documented health, functional or social need for the requested SSBCI benefit.

CCA makes the final eligibility determination, including whether the patient qualifies for a specific SSBCI benefit. Having a listed condition does not automatically qualify the patient for the benefit. CCA SSBCI benefits are applicable to members enrolled in CCA Senior Care Options (HMO D-SNP).

Instructions

This form should be completed by a treating clinician with records and credentials sufficient to assess the patient's condition and the criteria above.

1. Complete the **Provider Information** and **Patient Information** sections.
2. Select at least one **Qualifying Active Chronic Condition** supporting this attestation.
3. Complete the **Clinical Attestation** and **Certification** sections.
4. **Sign** and **submit** the form.
   - **Fax:** 937-396-3950
   - **Email:** SSBCI@CareSource.com
   - **Mail:** SSBCI Provider Attestation
P.O. Box 1003
Dayton, OH 45401-1003

You also can complete this form electronically in the Provider Portal.

Patient Information

Include Patient Name, Date of Birth and at least one of the following: Medicare ID, Medicaid ID or CCA Member ID.

Patient Name*_____ Date of Birth*_____

Medicare ID_____ Medicaid ID (if applicable)_____

CCA Member ID_____

Provider Information

Provider Name*_____ NPI*_____

Credentials/Title_____ Phone_____

**Required Field*

Qualifying Active Chronic Conditions

Select the active qualifying chronic conditions supporting this attestation:

- ☐ Autoimmune disorders
- ☐ Cancer
- ☐ Cardiovascular disorders
- ☐ Chronic alcohol use disorder and other SUDs
- ☐ Chronic and disabling mental health conditions
- ☐ Chronic sensory impairment conditions
- ☐ Chronic gastrointestinal disease
- ☐ Chronic heart failure
- ☐ Chronic kidney disease (CKD)
- ☐ Chronic lung disorders
- ☐ Conditions with cognitive impairment
- ☐ Conditions with functional challenges
- ☐ Continued therapy services needed to maintain function
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ HIV/AIDS
- ☐ Immunodeficiency/ immunosuppressive disorders
- ☐ Neurologic disorders
- ☐ Overweight, obesity and metabolic syndrome
- ☐ Post-organ transplantation
- ☐ Severe hematologic disorders
- ☐ Stroke

Clinical Attestation

Based on my records and professional judgment, I confirm the following:

- **Serious health or functional impact:** The selected condition is life threatening or significantly limits the patient's overall health or function.
- **Risk of adverse outcome:** The patient is at high risk of hospitalization or another adverse health outcome.
- **Intensive care coordination:** The patient requires intensive care coordination to manage health needs.
- **Benefit-specific need:** The patient has a documented health, functional, environmental, or social need that supports the use of the requested SSBCI benefit, and the benefit is reasonably expected to help maintain or improve the patient's health, safety, or overall functioning.

Certification

☐ I certify that the information above is accurate to the best of my knowledge and supported by information available in the patient's record. I understand CCA will apply its plan criteria and make the final SSBCI and benefit-specific eligibility determination.

Provider signature_____ Date _____

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