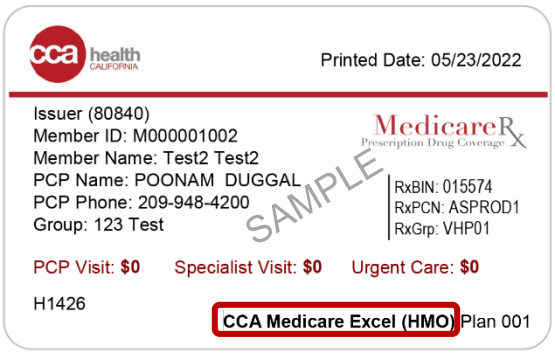
Instructions for Coverage Decision Request Form
Supplemental Benefits for the Chronically Ill

Members with certain health conditions or adverse health outcomes may be eligible for additional benefits. We call these Special Supplemental Benefits for the Chronically Ill (SSBCI benefits). To qualify for SSBCI benefits, CCA Health California must document that you have an active qualifying chronic condition.

Please read these instructions carefully before you submit this form to us. **You must complete all fields on the form and attach the required documentation. Forms that are received without the required information or documentation may result in a delay in processing, or a dismissal of your coverage request.**

Your Health Plan

If you aren't sure which health plan you are enrolled in, check your member ID card. The plan type is located at the bottom of your member ID card.



Member ID or Medicare ID

Please provide your member ID number. If you are a new member, and you do not know your Member ID, you can provide us with the Medicare Number from your red, white and blue Medicare card.

Provider Information

Please tell us about the provider who diagnosed you, or the provider you see most often for treatment of your chronic illness. We may need to contact them about your coverage request. Knowing their contact information helps avoid delays in processing your coverage request.

Proof of qualifying condition(s)

Your coverage request for SSBCI benefits must include supporting documentation that you have an active qualifying chronic condition. Valid documentation must include your diagnosis, date of the diagnosis, provider name and their NPI number and contact information. You can find a list of qualifying conditions on the next page.

Supplemental Benefits for the Chronically Ill Qualifying Chronic Conditions

Autoimmune disorders limited to:

- Polyarteritis nodosa
- Polymyalgia rheumatica
- Polymyositis
- Rheumatoid arthritis
- Systemic lupus erythematosus

Chronic and disabling mental health conditions

- Bipolar disorders
- Major depressive disorders
- Paranoid disorder
- Schizophrenia
- Schizoaffective disorder

Cardiovascular disorders limited to:

- Cardiac arrhythmias
- Coronary artery disease
- Peripheral vascular disease
- Chronic venous thromboembolic disorder

Cancer
Excluding pre-cancer conditions or in-situ status

Chronic alcohol and other drug dependence

Chronic heart failure

Dementia
Including Alzheimer's

Chronic lung disorders

- Asthma
- COPD
- Chronic bronchitis
- Emphysema
- Pulmonary fibrosis
- Pulmonary hypertension

Severe hematologic disorders limited to:

- Aplastic anemia
- Hemophilia
- Immune thrombocytopenic purpura
- Myelodysplastic syndrome
- Sickle-cell disease (excluding sickle-cell trait)
- Chronic venous thromboembolic disorder

Neurologic disorders limited to:

- Amyotrophic lateral sclerosis (ALS)
- Epilepsy
- Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
- Huntington's disease
- Multiple sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Polyneuropathy
- Spinal stenosis
- Stroke-related neurologic deficit

Diabetes

End-stage liver disease

End-stage renal disease (ESRD)

HIV/AIDS

Stroke

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Submit this form with supporting documentation that you have an active qualifying chronic condition.

By Mail: CCA Health California
Member Services Department
18000 Studebaker Road, Suite 150
Cerritos, CA 90703

By Fax: 1-866-207-6539

Your Health Plan

Select the health plan that you are a member of:

☐ CCA Medicare Excel (HMO)

Member Information

Last Name: _____ First Name: _____ Middle Initial: ___

Member ID or Medicare ID: _____ Date of Birth: _____ / _____ / _____

Home Phone: _____ Cell Phone: _____

Description of supporting documentation you are providing: _____

_____

_____

Example: I am including a copy of a discharge summary from a recent hospital visit that documents my diagnosis of diabetes.

Use another sheet of paper to include any additional information if needed.

Provider Information

Provider Name: _____ Provider Phone: _____

Address: _____

City: _____ State: CA Zip Code: _____

Provider Fax: _____

Sign Below

I understand that by submitting this form and my supporting documentation of a qualifying chronic condition, I am asking CCA Health California to make a Coverage Decision. A coverage decision is a decision we make about your benefits and coverage. We will review your request and your supporting documentation and send you a letter with our decision. In some cases, we might decide that the supporting information provided is insufficient for us to confirm that you have an active qualifying condition. If you disagree with the coverage decision, you will receive information explaining how to appeal our decision.

In limited circumstances, a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Print Name: _____

Signature: _____ **Date:** _____/_____/_____
Member/Patient or Personal Representative*

**If this form is being completed by an Authorized or Personal Representative, please print your name, phone number, and email in the section below. Check (✓) the box that shows your legal authority under law to sign this form on the Member/Patient's behalf.*

Please return this completed form with supporting documentation.

Personal/Authorized Representative Information

First Name: _____ Last Name:_____

Phone: _____ Email: _____

☐ HIPAA Agent/Representative ☐ Health Care Agent/Proxy ☐ Other Advocate

☐ Attorney ☐ Representative of Estate/Executor ☐ Power of Attorney

☐ Guardian Conservator