Dear Provider,

Our patients with certain health conditions or adverse health outcomes may be eligible for additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI). One of your patients has elected to enroll in a CCA Plan.

To help determine if your patient is eligible, we'll need some information from you. Please complete the attached attestation form and fax it to us at **413-733-1924 or mail:**

Commonwealth Care Alliance
101 Wason Avenue, 3rd floor
Springfield, MA 01107

As a reminder members are eligible for an Annual wellness and/or physical exam once per year.

We're here to help you promote good health for our members. If you have questions, please call our Provider Services team at**:**

California: 866-333-3530
Michigan: 855-959-5855
Massachusetts: 866-420-9332
Rhode Island: 866-420-9332

Sincerely,

Nazlim Hagmann, M.D.

Ayse Nazlim Hagmann, M.D.
Chief Medical Officer

Provider Attestation of Patient Diagnosis

To qualify for Special Supplemental Benefits for the Chronically Ill, your patient must:

1. Have a documented and active qualifying chronic condition
2. Require intensive care management and
3. Be at high risk for hospitalization.

Please complete the attached attestation verifying the member is at risk and which of the one or more listed qualifying conditions the member has been diagnosed with during the past 12 months. Then **fax** this form to **413-733-1924 or mail to the following:**

Commonwealth Care Alliance
101 Wason Avenue, 3rd floor
Springfield, MA 01107

ALL FIELDS MUST BE COMPLETED

PATIENT ENROLLED PLAN:

☐ **CCA CALIFORNIA** ☐ **CCA MASSACHUSETTS** ☐ **CCA MICHIGAN** ☐ **CCA RHODE ISLAND**

Patient Information

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

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

Address: _____

City: _____ State: _____ ZIP Code: _____

Provider Information (Provider to complete)

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Provider Attestation (continued from previous page)

I confirm my records for this patient include a diagnosis of one or more of the following qualifying conditions and the patient is at high risk of hospitalization or other adverse health outcomes.

Please check all that apply.

☐ **Autoimmune disorders limited to:**
- Polyarteritis nodosa,
- Polymyalgia rheumatica,
- Polymyositis,
- Rheumatoid arthritis, and
- Systemic lupus erythematosus;

☐ **Cancer** excluding pre-cancer conditions or in-situ status

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

☐ **Chronic alcohol and other drug dependence**

☐ **Chronic heart failure**

☐ **Chronic and disabling mental health conditions**
- Bipolar disorders,
- Major depressive disorders,
- Paranoid disorder,
- Schizophrenia, and
- Schizoaffective disorder;

☐ **Chronic lung disorders**
- Asthma,
- COPD
- Chronic bronchitis,
- Emphysema,
- Pulmonary fibrosis, and
- Pulmonary hypertension;

☐ **Dementia** including Alzheimers

☐ **Diabetes**

☐ **End-stage liver disease**

☐ **End-stage renal disease (ESRD)**

☐ **HIV/AIDS**

☐ **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, and
- Stroke-related neurologic deficit; and

☐ **Severe hematologic disorders limited to:**
- Aplastic anemia,
- Hemophilia,
- Immune thrombocytopenic purpura,
- Myelodysplatic syndrome,
- Sickle-cell disease (excluding sickle-cell trait), and
- Chronic venous thromboembolic disorder

☐ **Stroke**

☐ **No, my records for this patient <u>do not</u> include a diagnosis of any of the above conditions and/or the patient <u>is not</u> at high risk of hospitalization or other adverse health outcomes.**

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

Provider Printed Name	Provider Signature Date	
Provider Signature	Provider Credential (ex. MD, PCP)	Provider NPI #