ULTIMATE HEALTH PLANS

Chronic Special Needs Plan (CSNP) Pre-Qualification Form

Ultimate Health Plans offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions: Cardiovascular Disease (CVD), Chronic Heart Failure (CHF), and Chronic Lung Disorder, Diabetes Mellitus (DM). You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. We will verify the presence of the chronic condition with your health care provider within 30 days of enrollment. We are required to disenroll you from the special needs plan if we cannot verify your chronic condition. Therefore, please let your doctor know that we will require their verification of the information below. Please provide us with accurate contact information for your doctor or other health care provider on this form.

Do You Have a Chronic Condition?

Has your doctor or other licensed healthcare professional diagnosed you with any of the following medical conditions? *(Check all that apply)*

Cardiovascular Disease (CVD): ❒ Yes ❒ No
Chronic Heart Failure (CHF): ❒ Yes ❒ No
Chronic Lung Disorder: ❒ Yes ❒ No
Diabetes Mellitus: ❒ Yes ❒ No

Cardiovascular Disease (CVD) *Plans 019, 021, 026, 029, 033*

1. Have you had or been told you're at risk of having a heart attack? ❒ Yes ❒ No
2. Have you received a stent in your heart? ❒ Yes ❒ No
3. Do you have a pacemaker, or do you take any medications for abnormal heart rhythm? ❒ Yes ❒ No
4. Has your doctor told you that you have reduced blood flow to your legs or feet? ❒ Yes ❒ No
5. Have you ever had a procedure to improve blood supply to your legs or feet? ❒ Yes ❒ No
6. Do you suffer from blood clots, or are you taking any long-term medications for blood clots? ❒ Yes ❒ No
7. Do you take any medications for your heart or circulation? ❒ Yes ❒ No

Chronic Heart Failure (CHF) *Plans 022, 024, 026, 029, 033*

1. Has your doctor told you that your heart is not pumping as well as it should? ❒ Yes ❒ No
2. Do you have swelling in your feet and legs almost every day due to too much fluid in your body? ❒ Yes ❒ No
3. Do you take a water pill due to a heart-related condition (such as heart failure)? ❒ Yes ❒ No
4. Do you take medication for the fluid in your lungs or to help your heart beat stronger? ❒ Yes ❒ No

Chronic Lung Disorder *Plans 023, 025, 027, 030, 034*

1. Do you suffer from breathing problems due to lung disease (emphysema, chronic bronchitis, asthma, or fibrosis of lungs)? ❒ Yes ❒ No
2. Has your doctor told you that you have permanent lung damage due to smoking or inhalation of toxins? ❒ Yes ❒ No
3. Has your doctor prescribed you any medications (such as a breathing pump, steroids) or extra oxygen to help you breathe better? ❒ Yes ❒ No

Diabetes Mellitus (DM) *Plans 019, 021, 026, 029, 033*

1. Do you regularly check your blood sugar at home? ❒ Yes ❒ No
2. Have you been diagnosed with high blood sugar (diabetes)? ❒ Yes ❒ No
3. Do you take any medications to control your blood sugar? ❒ Yes ❒ No

Health Care Provider Contact Information

PROVIDER LAST NAME:

PROVIDER FIRST NAME:

PHONE NUMBER: ( )

FAX NUMBER: ( )

Beneficiary Information

LAST NAME:

FIRST NAME:

MI:

SIGNATURE:

TODAY'S DATE: *(MM/DD/YYYY)* / /