PRE-QUALIFICATION ASSESSMENT TOOL

MCS Classicare offers a Special Need Plan (SNP) for people with chronic conditions. You may be eligible to join MCS Classicare's special needs plan for chronic conditions if you can answer "Yes" to any of the questions below.

Please, complete this form and return it to us with your enrollment application. It is important that all sections in this formulary are completed to accurately process your enrollment request. MCS must validate your chronic condition with your doctor within 30 days of the effective date of enrollment. If we are unable to verify your chronic condition, we need to disenroll you from this plan.

BENEFICIARY INFORMATION

Last name:	Name:	Initial:
Date of birth: _____ (Month / Day / Year)	Medicare beneficiary identifier:	
	Phone number #1:	Phone number #2:

CLINICAL QUESTIONS TO QUALIFY YOUR CHRONIC CONDITION(S)

DIABETES MELLITUS		
Have you been diagnosed by your doctor or other licensed healthcare professional with diabetes?	☐ Yes	☐ No
Have you presented increased thirst, frequent urination, increased appetite, unexplained weight loss, slow wound healing or frequent infections?	☐ Yes	☐ No
Have you had high blood sugar?	☐ Yes	☐ No
Has your physician ordered treatment to control blood sugar levels? Example: insulin	☐ Yes	☐ No
Do you have or have you had a special diet to control your blood sugar?	☐ Yes	☐ No
CHRONIC HEART FAILURE		
Have you been diagnosed by your doctor or other licensed healthcare professional with chronic or congestive heart failure (CHF)?	☐ Yes	☐ No
Have you had problems with fluid retention in your lungs or swelling in your legs due to heart problem?	☐ Yes	☐ No
Do you take medications to prevent legs or hand swelling? (medications that increase the urge to urinate)	☐ Yes	☐ No
Do you need to use more than pillow between your neck and back to help you breathe better when you sleep?	☐ Yes	☐ No
CARDIOVASCULAR DISORDERS		
Have you been diagnosed by your doctor or other licensed healthcare professional with cardiac arrhythmia, or coronary artery disease (angina), blood clots or vascular disease of legs?	☐ Yes	☐ No
Have you had palpitations in your chest?	☐ Yes	☐ No
Have you had problems with chest pain or tightness, shortness of breath, heart attack (cardiac infarction) or stroke?	☐ Yes	☐ No

HEALTH CARE PROVIDER(S) WHO CAN VERIFY YOUR CONDITION(S)

Physician name:	**Specialty:**	**City:**
Physician phone number:	**Physician fax number:**	**Does he/she work at any hospital that you are aware of?**

Physician name:	**Specialty:**	**City:**
Physician phone number:	**Physician fax number:**	**Does he/she work at any hospital that you are aware of?**

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO VERIFY CHRONIC CONDITION(S)

I hereby authorize the providers listed above to disclose my protected health information to MCS Advantage, Inc., to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in MCS Classicare's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Information disclosed as a result of this authorization will be protected by MCS Advantage in accordance with applicable state and federal laws and requirements.

Beneficiary signature:	
Authorized representative signature:	**Relationship:**
Date:	

PROVIDER ATTESTATION

I hereby attest that my patient listed above has the following chronic medical condition(s):

Chronic heart failure (CHF)	☐ Yes	☐ No
Cardiovascular disorders (CVD) (Please select the type of disorder that applies) ☐ Cardiac arrhythmias ☐ Coronary artery disease ☐ Peripheral vascular disease ☐ Chronic venous thromboembolic disorder	☐ Yes	☐ No
Diabetes mellitus	☐ Yes	☐ No

Provider name and/or representative:	**Provider signature and/or representative:**
Date:	**Provider address:**

MCS Classicare Primero (HMO C-SNP)