Verification of Chronic Conditions (VCC) Form

Thank you for choosing ATRIO Health Plans.

To remain enrolled in the Chronic Condition Special Needs Plan (C-SNP), we must verify that you have at least one qualifying chronic condition. To help us complete this requirement, we have enclosed a Verification of Chronic Conditions (VCC) Form.

Please take the attached form to the healthcare provider who manages your care and ask them to complete and return it to ATRIO Health Plans as soon as possible.

If you already have a Primary Care Provider (PCP), please call the SNP (Special Needs Plan) Team at 1-877-484-8637 and provide your provider's information. We can contact your provider to obtain the necessary information to verify your eligibility for the C-SNP plan.

Your provider only needs to verify **one** of the following qualifying conditions:

- Diabetes Type 1 or Type 2
- Congestive Heart Failure
- Atrial Fibrillation
- Peripheral Vascular Disease
- Coronary Artery Disease
- Chronic Blood Clots

Only one qualifying condition is required to remain eligible for the C-SNP plan.

ATRIO attempts to obtain the information needed to verify eligibility whenever possible. However, receiving a completed VCC form from your provider is often the fastest and most reliable way to confirm your eligibility.

Failure to verify a qualifying chronic condition may result in disenrollment from the C-SNP plan.

We encourage you to provide the attached form to your provider as soon as possible and stress the importance of completing and returning it promptly.

If you have questions or need assistance, please contact the SNP Team at **1-877-484-8637**.

Thank you for your prompt attention to this matter.

Verification of Chronic Conditions Form (VCC)

The individual listed below has elected to enroll in an ATRIO Health Plans Chronic Condition Special Needs Plan (C-SNP). CMS requires verification from a health care provider that the patient has at least one qualifying chronic condition. To support the member's continued enrollment in the plan, please review, sign, and return this form within **14 calendar days of receipt**. Failure to obtain provider verification may result in the member being disenrolled from the plan.

Please complete the fields below. Required fields identified with **bold text**.

Section 1. Patient demographic	
Member's first name:	**Member's last name:**
Date of birth (MM/DD/YYYY):	**Medicare ID number:**
Member phone number (including area code):	ATRIO member ID (if available):

Section 2: Condition verification

Select at least one condition or indicate that the patient has none. Then sign the form and provide your title and office phone number. Your signature confirms whether the patient has been diagnosed with one or more of the severe or disabling chronic conditions listed below.

Diabetes Mellitus:	**Congestive Heart Failure (CHF):**	**Cardiovascular Disease:**
○ Yes ○ No	○ Yes ○ No	○ Yes ○ No If **yes**, check all that apply: ○ Cardiac Arrhythmias ○ Coronary Artery Disease ○ Peripheral Vascular Disease ○ Chronic Venous Thromboembolic Disorder

○ PATIENT **DOES NOT** HAVE ANY OF THE ABOVE CHRONIC CONDITIONS

Office Phone number (including area code):	**Fax Number (including area code):**
Provider NPI or TIN **NPI:**	**TIN:**
Name/Title:	**Signature/date:**

Return the completed form using one of the following methods:

Fax Submission	**Secure Email Submission**
Include a PHI cover sheet and fax to 541-672-8670. **Attention: SNP Team**	Scan the completed form and send via secure email to: dnspcm@atriohp.com