



**of Tennessee**

1 Cameron Hill Circle  
Chattanooga, TN 37402  
bcbstmedicare.com

Dear \_\_\_\_\_,

Our Medicare Advantage Chronic Condition Special Needs Plan (C-SNP) is designed for people with diabetes, cardiovascular disorders and/or chronic heart failure who are enrolled in Medicare Parts A and B. Medicare requires us to have a provider attestation that has a formal diagnosis of diabetes mellitus, cardiovascular disorders and/or chronic heart failure. Please complete this simple attestation and return it to us by \_\_\_\_\_. If we don't receive confirmation by this date, the member will be disenrolled from the C-SNP plan. Thank you, as always, for your help.

Sincerely,

Your Provider Service Team

**Mail this form to:**

BlueCross BlueShield of Tennessee  
Attn: C-SNP Provider Attestations  
1 Cameron Hill Circle, Suite 0005  
Chattanooga, TN 37402

**Fax this form to:**

**(423) 535-1932**

**Complete this form online:**

**<https://provider.circlecompare.ai/attestation>**

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If you should have any questions, please call Member Service at 1-888-542-2583, TTY 711, Monday through Friday, 9 a.m. to 5 p.m. ET. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association



## BlueAdvantage Provider Attestation

Total Heart and Diabetes (PPO C-SNP)<sup>SM</sup>

Total Heart and Diabetes Plus (PPO C-SNP)<sup>SM</sup>

The individual below has indicated they're one of your patients. To qualify for continued enrollment, Medicare requires one of the individual's treating physicians to verify they've been diagnosed with the qualifying condition of diabetes, cardiovascular disorders, and/or chronic heart failure. Without this signed attestation, the individual must be disenrolled from the C-SNP plan. **Please submit this form no later than**

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### Patient's Information

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Medicare Beneficiary Number: \_\_\_\_\_ 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 (Provider to complete)**

**Yes, my records for this patient include a diagnosis of one or more of the following qualifying chronic conditions:**

- **Diabetes Mellitus**
- **Cardiovascular Disorders**
- **Chronic Heart Failure**

**No, my records for this patient don't include a diagnosis of any of the above chronic conditions.**

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

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Provider Printed Name

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Provider Signature

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Provider Signature Date