



of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402
medicare.bcbst.com

Dear Member,

Please take this form to your provider and ask them to fill it out. We need to have this completed form on file for you to get your benefits and keep your plan. If we don't get your completed form within 30 days of your effective date, we'll have to disenroll you from this plan.

Dear Provider,

Our Medicare Advantage Chronic Condition Special Needs Plan (C-SNP) is for people with diabetes, cardiovascular disorders and/or chronic heart failure who have Medicare Parts A and B. We need to know if your patient has one of these formal diagnoses. Please complete this form and return it to us within 30 days of their effective date. If we don't get it by then, we'll have to disenroll them from their C-SNP plan. Thank you 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

If you have any questions, please call Member Service at **800-831-2583**, TTY **711**. From Oct. 1 to March 31, you can call us from 8 a.m. to 9 p.m., ET, seven days a week. From April 1 to Sept. 30, you can call us from 8 a.m. to 9 p.m., ET, Monday through Friday. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association



of Tennessee

BlueAdvantage Provider Attestation

Total Heart and Diabetes (PPO C-SNP)SM | Total Heart and Diabetes Plus (PPO C-SNP)SM

For someone to qualify for this C-SNP plan, we need you to confirm they've been diagnosed with diabetes, cardiovascular disorders and/or chronic heart failure. If we don't get this signed form back within 30 days of their effective date, we'll have to disenroll them from their C-SNP plan.

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BlueCross BlueShield of Tennessee
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Chattanooga, TN 37402

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Member's Information (Provider or member to complete)

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

Medicare Beneficiary Number: _____ Date of Birth: _____ Phone: _____

Provider Information (Provider to complete)

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Provider Attestation (Provider to complete)

☐ Yes, this patient's record includes a diagnosis of **Diabetes Mellitus, Cardiovascular Disorders** and/or **Chronic Heart Failure** and meets all of the following:

1. is life threatening or significantly limits the overall health or function of the individual;
2. has a high risk of hospitalization or other adverse health outcomes; and
3. requires intensive care coordination.

☐ No, this patient's record doesn't include a diagnosis of any of these chronic conditions.

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

Provider Printed Name

Provider Signature

Provider Signature Date