

# Health Net (HMO C-SNP) Pre-enrollment Qualification Assessment Tool



Health Net is a Medicare Advantage Special Needs Plan (SNP) designed for people with chronic conditions such as diabetes, chronic heart failure and certain cardiovascular disorders.

## Enrollee information

Last name:  First name:  MI:

Medicare number:  Phone number:  -  -

Birth date:

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Please complete and submit this form with your enrollment application. If you can answer “Yes” or “Not sure” to any of the following questions, you may be eligible to join our chronic care SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into Health Net. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from the Special Needs Plan.

## Chronic condition questions

- Have you been diagnosed with diabetes?  Yes  No  Not sure
- Have you had problems with high blood sugar?  Yes  No  Not sure
- Do you take medication and/or have you been put on a special diet to control your blood sugar?  Yes  No  Not sure
- Have you been diagnosed with chronic (or congestive) heart failure (CHF)?  Yes  No  Not sure
- Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem?  Yes  No  Not sure
- Do you take medication to prevent fluid retention?  Yes  No  Not sure
- Have you been diagnosed with any of the following cardiovascular disorders?  Yes  No  Not sure
  - Cardiac arrhythmia
  - Chronic venous thromboembolic disorder
  - Coronary artery disease
  - Peripheral vascular disease
- Have you had problems with rapid, erratic heartbeats?  Yes  No  Not sure
- Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke?  Yes  No  Not sure
- Has a physician ever told you that you have a blood clot?  Yes  No  Not sure

(continued)

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**Health care provider(s) who can verify your chronic condition(s)**

**PROVIDER #1**

Provider name:

Provider address:

Provider phone:

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Provider fax:

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**PROVIDER #2**

Provider name:

Provider address:

Provider phone:

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Provider fax:

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**Authorization for Disclosure of Health Information to Verify Chronic Condition(s):**

I hereby authorize the disclosure of my health information by the providers listed above to Health Net in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in Health Net 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 Health Net in accordance with applicable state and federal laws and requirements.

**Signature**

Enrollee signature:

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

Broker/Agent name (if applicable):

Broker/Agent signature (if applicable):

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M	D	D	Y	Y	Y	Y

For more information or for assistance with this form, please call Member Services at 1-800-431-9007 (TTY: 711).

Hours of operation: From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

Health Net is contracted with Medicare for HMO SNP plans. Enrollment in Health Net depends on contract renewal.

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