Verification of Chronic Condition (VCC) Forms at the Time of Sale

Medicare Advantage Chronic Condition Special Needs Plans (C-SNP)

Medicare Enrollment SNP

May 2026

Humana®

CarePlus HEALTH PLANS™

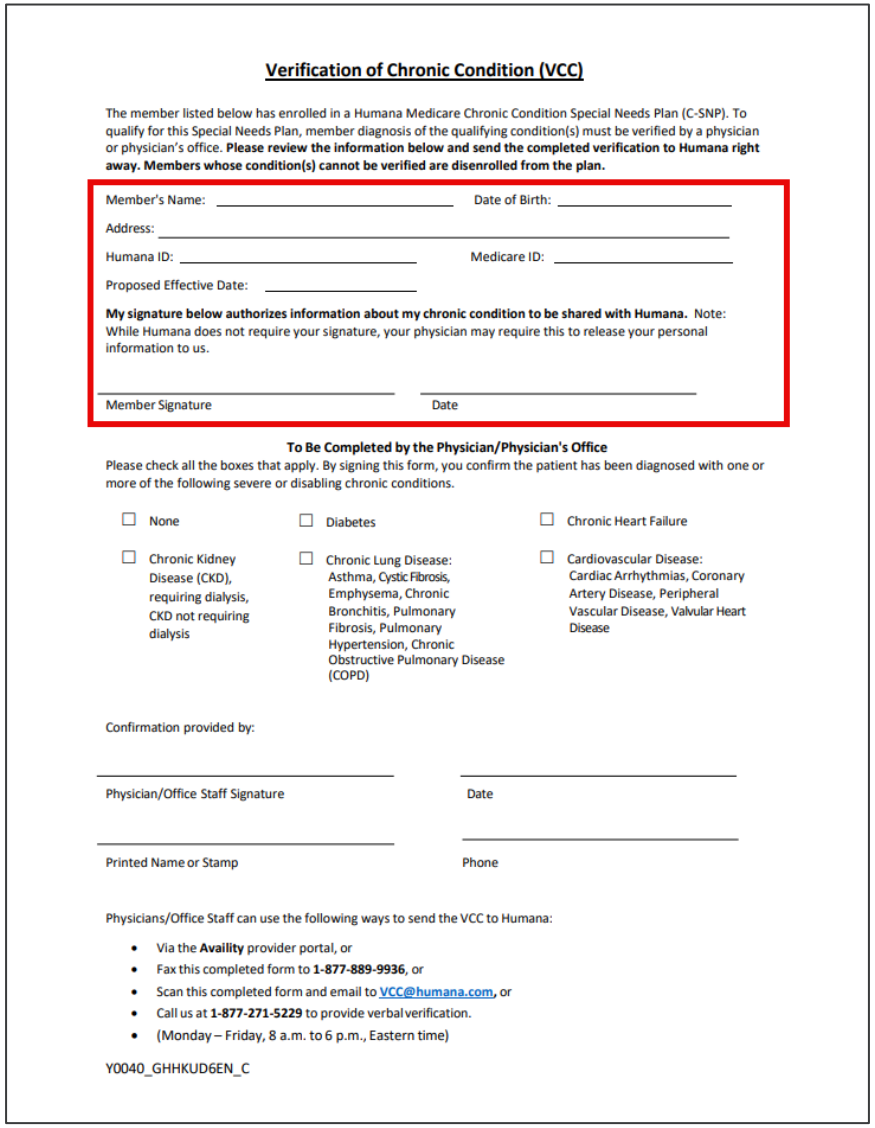
VCC Forms at the Time of Sale

- **Educate the member about the VCC requirement for C-SNPs**
  - The member must take the VCC form to their provider/provider's office that will verify their chronic condition
  - The provider/provider's office must complete, sign and submit the form to Humana or CarePlus on or before the last day of the second month of enrollment
  - If the form is not received by Humana or CarePlus timely, the member is involuntarily disenrolled
- **Agents are allowed to leave VCC forms with C-SNP enrollees at the point of sale, when it makes sense to do so**
  - Members will still receive a pre-populated VCC form with their acknowledgement letter
  - The form only needs to be completed once
- **The form should NOT be returned with the application**
- **Agents should NOT reach out to the provider on a member's behalf**

Humana VCC Form Required Information

- **Agents are responsible for completing the top portion of the form with the member's information**
  - Name
  - Date of Birth
  - Address
  - Humana ID

    (If the member has no prior Humana coverage, they will not have a Humana ID)
  - Medicare ID
  - Proposed Effective Date
- **Members are responsible for signing and dating the form before their provider completes the bottom portion of the form**
  - Member Signature
  - Date



Verification of Chronic Condition (VCC)

The member listed below has enrolled in a Humana Medicare Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to Humana right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name: _____ Date of Birth: _____

Address: _____

Humana ID: _____ Medicare ID: _____

Proposed Effective Date: _____

My signature below authorizes information about my chronic condition to be shared with Humana. Note: While Humana does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

To Be Completed by the Physician/Physician's Office

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

☐ None ☐ Diabetes ☐ Chronic Heart Failure

☐ Chronic Kidney Disease (CKD), requiring dialysis, CKD not requiring dialysis

☐ Chronic Lung Disease: Asthma, Cystic Fibrosis, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease (COPD)

☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to Humana:

- Via the **Availity** provider portal, or
- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **VCC@humana.com**, or
- Call us at **1-877-271-5229** to provide verbal verification.
- (Monday – Friday, 8 a.m. to 6 p.m., Eastern time)

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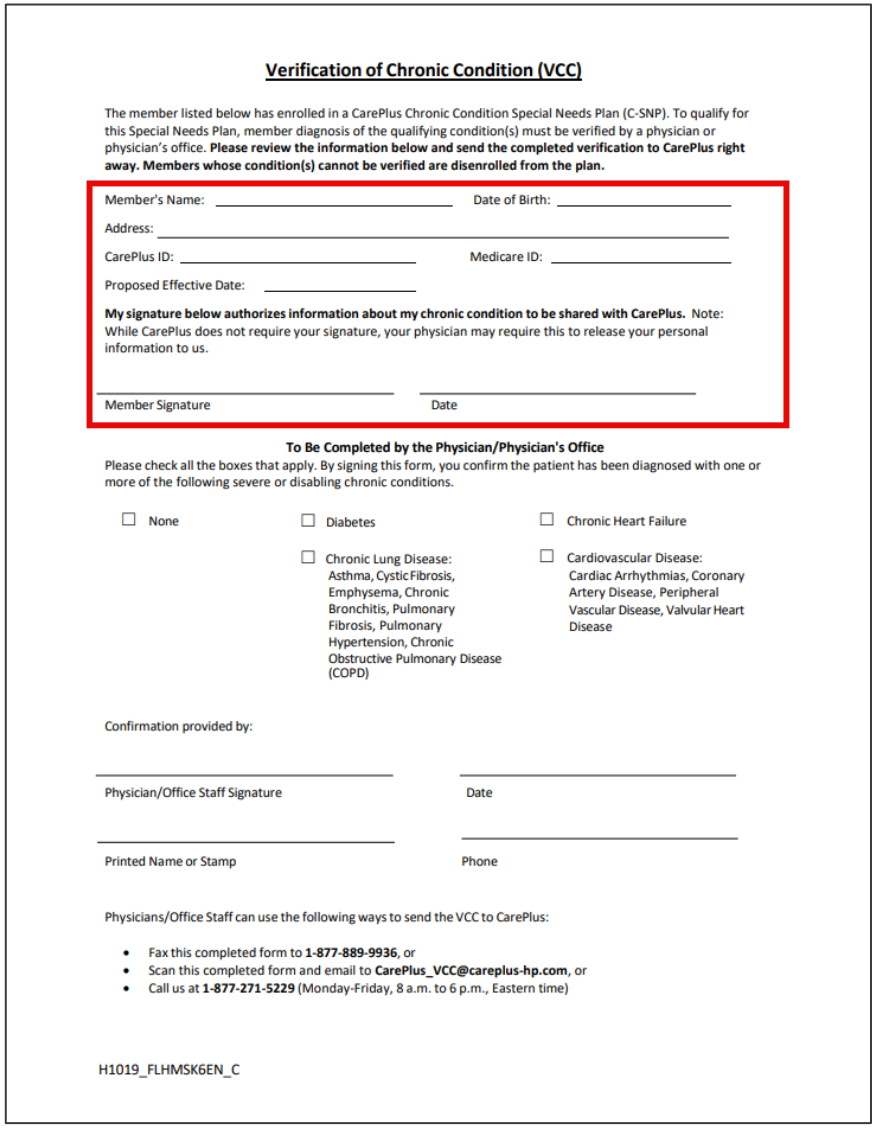
CarePlus VCC Form Required Information

- **Agents are responsible for completing the top portion of the form with the member's information**
  - Name
  - Date of Birth
  - Address
  - CarePlus ID

    (If the member has no prior CarePlus coverage, they will not have a CarePlus ID)
  - Medicare ID
  - Proposed Effective Date
- **Members are responsible for signing and dating the form before their provider completes the bottom portion of the form**
  - Member Signature
  - Date



Verification of Chronic Condition (VCC)

The member listed below has enrolled in a CarePlus Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to CarePlus right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name: _____ Date of Birth: _____

Address: _____

CarePlus ID: _____ Medicare ID: _____

Proposed Effective Date: _____

My signature below authorizes information about my chronic condition to be shared with CarePlus. Note: While CarePlus does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

To Be Completed by the Physician/Physician's Office

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

☐ None

☐ Diabetes

☐ Chronic Heart Failure

☐ Chronic Lung Disease: Asthma, Cystic Fibrosis, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease (COPD)

☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to CarePlus:

- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **CarePlus_VCC@careplus-hp.com**, or
- Call us at **1-877-271-5229** (Monday-Friday, 8 a.m. to 6 p.m., Eastern time)

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