# 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)