BlueCare Plus
Tennessee

Provider Attestation of Patient Diagnosis

To qualify for Special Supplemental Benefits for the Chronically Ill, your patient must have been diagnosed with one or more of the conditions listed on the following page and be at high risk of hospitalization or other adverse health outcomes.

Please complete the attached attestation verifying the member is at risk and has been diagnosed with one or more of the conditions listed during the past 12 months. Then fax this form to **1-855-876-1461**.

If you have questions, please call our Care Coordination team at **1-877-715-9503**, TTY **711**. They're available from 8 a.m. to 6 p.m. ET, Monday through Friday.

Patient's Information (Patient to complete)

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

Subscriber ID: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP Code: _____

Provider Information (Provider to complete)

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

BlueCare Plus Tennessee

Provider Attestation (continued from previous page)

I confirm my records for this patient include a diagnosis of one or more of the following qualifying conditions and the patient is at high risk of hospitalization or other adverse health outcomes.

Please check all that apply.

- ☐ Autoimmune disorders
- ☐ Cancer
- ☐ Cardiovascular disorders
- ☐ Chronic alcohol use disorder and other substance use disorders (SUDs)
- ☐ Chronic and disabling mental health conditions
- ☐ Chronic gastrointestinal disease
- ☐ Chronic heart failure
- ☐ Chronic kidney disease (CKD)
- ☐ Chronic lung disorders
- ☐ Conditions associated with cognitive impairment
- ☐ Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- ☐ Conditions with functional challenges and require similar services including the following: spinal cord injuries, paralysis, limb loss and arthritis
- ☐ Chronic conditions that impair vision, hearing (deafness), taste, touch and smell
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ HIV/AIDS
- ☐ Immunodeficiency and Immunosuppressive disorders
- ☐ Neurological disorders
- ☐ Overweight, obesity, or metabolic syndrome
- ☐ Post-organ transplantation care
- ☐ Severe hematologic disorders
- ☐ Stroke

☐ No, my records for this patient don't include a diagnosis of any of the above conditions and/or the patient isn't at high risk of hospitalization or other adverse health outcomes.

As part of your patient's Interdisciplinary Care Team, you can bill and be reimbursed when you supply this information.

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

Provider Printed Name	Provider Signature Date
Provider Signature	Provider Credential