BlueCare Plus
Tennessee

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

Dear Provider,

Your patients with certain health conditions or adverse health outcomes may be eligible for additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI).

To help determine if your patient is eligible, we'll need some information from you. Please complete the attached attestation form and fax it to us at **1-855-876-1461**. As part of your patient's Interdisciplinary Care Team, you can bill and be reimbursed just for supplying this information.

We're here to help you promote good health for our members. If you have questions, please call our Care Coordination team at **1-877-715-9503**.

Sincerely,

Linda M. Pate MD FACS

Linda M. Pate, MD, FACS
Senior Medical Director, BlueCare Plus Tennessee

BlueCare Plus Tennessee, an independent licensee of the Blue Cross Blue Shield Association.

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.**

Patient's Information

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

Member ID: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Provider Information (Provider to complete)

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

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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 and other drug dependence**
- ☐ **Chronic and disabling mental health conditions**
- ☐ **Chronic heart failure**
- ☐ **Chronic lung disorders**
- ☐ **Dementia**
- ☐ **Diabetes**
- ☐ **Disabled members**
- ☐ **End-stage liver disease**
- ☐ **End-stage renal disease (ESRD)**
- ☐ **HIV/AIDS**
- ☐ **Members with endocrine disorders**
- ☐ **Members with joint and spine conditions**
- ☐ **Members with obesity**
- ☐ **Neurologic disorders**
- ☐ **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.**

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