GlobalHealth
MEDICARE ADVANTAGE PLANS

Pre-Enrollment Qualification Assessment Tool

Chronic Special Needs Plan (C-SNP) is a type of Medicare Advantage coordinated plan focused on individuals with chronic special needs. GlobalHealth offers chronic special needs plans designed for people with certain chronic or disabling conditions.

You may be eligible to join one of GlobalHealth's C-SNPs if you can answer YES to any of the questions below. GlobalHealth will need to obtain verification of the chronic condition from your doctor within the first month of enrollment. If we are unable to verify your chronic condition, we must disenroll you from this chronic special needs plan. It is very important that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

CLINICAL QUESTIONS TO PRE-QUALIFY YOUR ELIGIBILITY IN A C-SNP

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions? (Check all that apply)

Chronic Heart Failure (CHF)	☐ Yes ☐ No
Cardiovascular Disorder	☐ Yes ☐ No
Diabetes Mellitus	☐ Yes ☐ No

Chronic Heart Failure

Do you have fluid in your lungs?	☐ Yes ☐ No
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	☐ Yes ☐ No
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	☐ Yes ☐ No

Cardiovascular Disorder

Have you had a heart attack or been told by your doctor you are at risk to have one?	☐ Yes ☐ No
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	☐ Yes ☐ No
Do you take medicine for your heart or circulation?	☐ Yes ☐ No

Diabetes Mellitus

Do you check your blood sugar at home?	☐ Yes ☐ No
Do you have high blood sugar?	☐ Yes ☐ No
Do you take medicine to control your blood sugar?	☐ Yes ☐ No

Beneficiary Information

Beneficiary Name:

Last Name: First Name: (Optional) MI:

Birth Date:

M M D D Y Y Y Y

Medicare ID Number (HICN):

I authorize the providers listed below to share my health information with GlobalHealth to verify that I have a chronic condition that qualifies me for enrollment in GlobalHealth's chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page. Note: GlobalHealth will protect information disclosed as a result of this authorization in accordance with any state and federal laws and requirements that apply. Call us if you have questions or need help with this form. You can reach us at 1-844-280-5555 (TTY: 711). Hours of operation are 8 a.m. to 8 p.m., seven days a week, (October 1 - March 31), and 8 a.m. to 8 p.m., Monday through Friday, (April 1 - September 30). Visit us at anytime at www.globalhealth.com.

Enrollee Signature:

Today's Date:

M M D D Y Y Y Y

Name of your Doctor or Health Care Provider:

Last Name: First Name: (Optional) MI:

Phone Number: Fax Number:

Name of your Doctor or Health Care Provider:

Last Name: First Name: (Optional) MI:

Phone Number: Fax Number: