healthteam advantage℠

This document is required for Diabetes & Heart Care (HMO C-SNP) applicants.

Chronic Condition Verification Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with federal law concerning the privacy of such information.

Release of Information

By joining HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP), a Medicare Advantage Special Needs Plan for Chronic Conditions, I acknowledge that I have one or more of the following conditions:

☐ **Diabetes** ☐ **Chronic Heart Failure**

I authorize and direct _____ (Care Provider/Specialist) to confirm my chronic condition and disclose my medical records to HealthTeam Advantage. This authorization shall be effective until I am no longer enrolled in HealthTeam Advantage.

Application Use and Disclosure Authorization

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative: _____

Medicare ID Number or Date of Birth: _____

Signature of Applicant/Authorized Representative: _____ Date: _____

If you are the authorized representative of the applicant, provide the following information:

Relationship to Applicant: _____ Phone Number: _____

Provider Confirmation of Chronic Condition

PROVIDER, please complete.

I, _____ (Provider)

hereby certify that _____ (Applicant)

has the following health condition(s):

☐ **Diabetes** ☐ **Chronic Heart Failure**

Provider: _____ **Date:** _____

Provider Address: _____

_____ **Provider Phone:** _____

Fax this completed form to: 800-820-0774

Mail this form to: HealthTeam Advantage, 300 E. Wendover Ave., Suite 121, Greensboro, NC 27401
If you have any questions, please call: 877-905-9216, TTY 711, Monday—Friday, 8:00 a.m.—5:00 p.m.

