



Special Supplemental Benefits for the Chronically III (SSBCI) Provider Attestation Form

According to the Centers for Medicare & Medicaid Service (CMS) guidelines, to qualify for Special Supplemental Benefits for the Chronically III (SSBCI), the health plan member must have been diagnosed with one or more eligible chronic conditions and meet the following criteria:

- The condition must be life-threatening or significantly limits overall health or function.
- The individual must have a high risk of hospitalization or other adverse health outcomes.
- Intensive care coordination is required.

Instructions for Completion

1. Complete the Provider Information section.

Fill out the required information in the *Provider Information* section.

2. Complete the Patient Information section.

Fill out the details pertaining to the member/patient, including information about eligible chronic conditions.

3. Complete the Provider Attestation section.

4. Submit the completed form.

- **Fax:** 937-396-3950
- **Email:** SSBCI@CareSource.com
- **Mail:** SSBCI Provider Attestation
P.O. Box 1003
Dayton, OH 45401-1003

You also can complete this form electronically in the [Provider Portal](#).

Provider Information

Provider Name _____ NPI _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Patient Information

Name _____ Date of Birth _____

Medicare ID _____ Medicaid ID (if applicable) _____

HAP CareSource™ MI Coordinated Health (HMO D-SNP) Member ID _____

Eligible Chronic Conditions

Which of the following eligible chronic conditions does the patient have? (Select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Functional Challenges |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Cardiovascular Disorders | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Substance Use Disorders | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Chronic and Disabling Mental Health Conditions | <input type="checkbox"/> Immunodeficiency and Immunosuppressive Disorders |
| <input type="checkbox"/> Sensory Impairments | <input type="checkbox"/> Neurologic Disorders |
| <input type="checkbox"/> Chronic Gastrointestinal Diseases | <input type="checkbox"/> Overweight, Obesity, and Metabolic Syndrome |
| <input type="checkbox"/> Chronic Heart Failure | <input type="checkbox"/> Post-Organ Transplantation |
| <input type="checkbox"/> Chronic Kidney Disease (CKD) | <input type="checkbox"/> Severe Hematologic Disorders |
| <input type="checkbox"/> Chronic Lung Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cognitive Impairment Conditions | |
| <input type="checkbox"/> Conditions Requiring Continued Therapy Services | |

Provider Attestation

- I confirm my records for the above-named patient indicate a diagnosis of a chronically ill individual with one or more of the active qualifying chronic conditions. Additionally, there has been documentation of the qualifying diagnosis within the past 12 months. I confirm the patient meets CMS's criteria for receiving SSBCI as outlined on this form.

By signing below, I certify the information provided above is correct and noted in the patient's medical records.

Signature _____ Date _____

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