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

According to the Centers for Medicare & Medicaid Service (CMS) guidelines, to qualify for Special Supplemental Benefits for the Chronically Ill (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 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) _____

CareSource® MyCare Ohio (HMO D-SNP) Member ID _____

Eligible Chronic Conditions

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

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

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**_____

H6396_OH-SNP-P-5367718_C