Chronic Special Needs Plan (CSNP)
Pre-Qualification Form

Sonder Health Plans offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions, Diabetes and Cardiovascular Disease (CVD). You may be eligible to join one of our chronic-care SNPs if you can answer YES to any of the questions below. We will verify the presence of the chronic condition with your health care provider within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification of the information below and that you provide us with accurate contact information for your doctor or other health care provider on this form.

Do You Have Cardiovascular Disease (CVD) or Diabetes?

Has your doctor or other licensed health-care professional diagnosed you with any of the following medical conditions?

Cardiovascular Disease (CVD): ☐ Yes ☐ No **Diabetes**: ☐ Yes ☐ No

Cardiovascular Disease (CVD)

Have you had a heart attack or blood clot or been told by your doctor you are at risk of having one?	☐ Yes	☐ No
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	☐ Yes	☐ No
Have you been told by your doctor that you have an irregular heartbeat (cardiac arrhythmia)?	☐ Yes	☐ No
Do you take medicine for your heart or circulation?	☐ Yes	☐ No

Diabetes

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

Health Care Provider Contact Information

PROVIDER LAST NAME _____ PROVIDER FIRST NAME _____

PROVIDER PHONE NUMBER _____ PROVIDER FAX NUMBER _____

Beneficiary Information

LAST NAME _____ FIRST NAME _____ MI _____

SIGNATURE _____ DATE _____

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 either the Sonder Diabetes Wellness Plan (C-SNP H1748003) **or** the Sonder Heart Healthy Plan (C-SNP H1748004), I acknowledge that I have one or more of the following conditions:

☐ **Diabetes** ☐ **Cardiovascular Disease (CVD)**

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

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: _____Telephone Number: _____

Provider Confirmation of Chronic Condition

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Care Provider/Specialist), hereby certify that _____(Applicant) has the following health condition(s): ☐ **Diabetes** ☐ **Cardiovascular Disease (CVD)**

Care Provider/Specialist Signature: _____Date: _____

Fax this completed form to: **1 (888) 216-5210**

Mail this form to:

Sonder Health Plans
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

If you have any questions, please call: 1-800-331-2928, TTY 711, 7 days a week, 8 am - 8 pm.

Sonder Health Plans, Inc. is an HMO with a Medicare contract.
Enrollment in Sonder Health Plans, Inc. depends on contract renewal.