Sonder Health
A Medicare Advantage Company

Supplemental Benefit Chronic Condition Verification Form

The individual listed below has elected to enroll in a plan that provides optional supplemental benefits for those members who suffer from Medicare approved chronic conditions.

For the member to receive these optional supplemental benefits, verification of an approved chronic condition is required.

Please complete and return to Sonder Health Plans via one of the methods identified below:

Section 1. Patient Demographic Information	
Member's First Name*	Member's Last Name*
Date of Birth (MM/DD/YYYY)*	Sonder Health Plan ID Number*
Member's Phone Number* ( ) -	

Section 2. Condition Verification

Please select at least one qualifying chronic condition below ***or*** select "Patient Does Not Have Any of the Above Chronic Conditions" if none of the conditions listed apply. By completing and signing this form, you confirm that the patient above has one or more of the Medicare approved chronic conditions listed below unless otherwise noted:

- ☐ **Chronic alcohol and/or other drug dependence**

Autoimmune disorders

- ☐ **Polyarteritis nodosa**
- ☐ **Polymyalgia rheumatica**
- ☐ **Polymyositis**
- ☐ **Dermatomyositis**
- ☐ **Rheumatoid arthritis**
- ☐ **Systemic lupus erythematosus**
- ☐ **Psoriatic arthritis**
- ☐ **Scleroderma**

- ☐ **Cancer, excluding pre-cancer conditions or in-situ status**

Cardiovascular disorders limited to:

- ☐ **Cardiac arrhythmias**
- ☐ **Coronary artery disease**
- ☐ **Peripheral vascular disease**
- ☐ **Valvular heart disease**

- ☐ **Chronic Heart Failure**
- ☐ **Chronic Hypertension**
- ☐ **Dementia**
- ☐ **Diabetes mellitus**
- ☐ **Overweight, obesity, and metabolic syndrome**

Chronic gastrointestinal diseases limited to:

- ☐ **Chronic liver disease**
- ☐ **Non-alcoholic fatty liver disease**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Pancreatitis**
- ☐ **Irritable bowel syndrome**
- ☐ **Inflammatory bowel disease**

Chronic kidney disease (CKD):

- ☐ **CKD requiring dialysis/End-stage renal Disease (ESRD)**
- ☐ **CKD not requiring dialysis**

Severe hematologic disorders limited to:

- ☐ **Aplastic anemia**
- ☐ **Hemophilia**
- ☐ **Immune thrombocytopenic purpura**
- ☐ **Myelodysplastic syndrome**
- ☐ **Sickle-cell disease (excluding sickle-cell trait)**
- ☐ **Chronic venous thromboembolic disorder**

- ☐ **HIV/AIDS**

Chronic lung disorders limited to:

- ☐ **Asthma, Chronic bronchitis**
- ☐ **Cystic Fibrosis**
- ☐ **Emphysema**
- ☐ **Pulmonary fibrosis**
- ☐ **Pulmonary hypertension**
- ☐ **Chronic Obstructive Pulmonary Disease (COPD)**

Chronic and disabling mental health condition limited to:

- ☐ **Bipolar disorders**
- ☐ **Major depressive disorders**
- ☐ **Paranoid disorder**
- ☐ **Schizophrenia**
- ☐ **Schizoaffective disorder**
- ☐ **Post-traumatic stress disorder (PTSD)**
- ☐ **Eating Disorders**
- ☐ **Anxiety disorders**

Neurologic disorders limited to: ☐ **Amyotrophic lateral sclerosis (ALS)** ☐ **Epilepsy** ☐ **Extensive paralysis (i.e., hemiplegia, quadriplegia, Paraplegia, monoplegia)** ☐ **Huntington's disease** ☐ **Multiple sclerosis** ☐ **Parkinson's disease** ☐ **Polyneuropathy** ☐ **Fibromyalgia** ☐ **Chronic fatigue syndrome** ☐ **Spinal cord injuries** ☐ **Spinal stenosis** ☐ **Stroke-related neurologic deficit** ☐ **Stroke** ☐ **Post-organ transplantation care** ☐ **Immunodeficiency and Immunosuppressive disorders** ***Conditions associated with cognitive impairment:*** ☐ **Alzheimer's disease** ☐ **Intellectual disabilities and developmental disabilities** ☐ **Traumatic brain injuries** ☐ **Disabling mental illness associated with cognitive impairment** ☐ **Mild cognitive impairment**	***Conditions with functional challenges and require similar services including the following:*** ☐ **Spinal cord injuries** ☐ **Paralysis** ☐ **Limb loss** ☐ **Stroke** ☐ **Arthritis** ☐ **Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell:** ***Describe above related condition:*** _____ _____ _____ _____ ☐ **Conditions that require continued therapy services in order for individuals to maintain or retain functioning:** ***Describe above related condition:*** _____ _____ _____ _____
☐ **PATIENT DOES NOT HAVE ANY OF THE ABOVE CHRONIC CONDITIONS**	
Office Phone Number* ( ) -	Fax Number* ( )
Please print Physician/Nurse Practitioner/Physician Assistant name*	Physician/Nurse Practitioner/Physician Assistant signature*
NPI *	Date signed*
Please return utilizing one of the methods below:	
Fax to: 1 (888) 531-4616 Attn: Enrollment Department	***Send Secure Email with completed form to:*** Applications_SonderEnrollments@sonderhealthplans.com