SPECIAL NEEDS PLAN (SNP) PRE-QUALIFICATION FORM

ALIGNMENT HEALTH PLAN

Tell Us About Yourself (Please Print)

Member Name _____ Date _____

Member DOB _____ Medicare ID # _____

Member Address _____

City _____ State _____

Zip Code _____ County _____ Member Phone # _____

Member Emergency Contact _____

Member Emergency Contact Phone # _____

Do you consider yourself to be homebound? ☐ Yes ☐ No

Physician Currently Treating the Applicant for the Qualifying Disease

Primary Care Physician Currently Treating the Condition(s)

Physician Name _____

Physician Phone # _____

Other Treating Specialists _____

Physician Name _____

Physician Phone # _____

☐ I authorize for AHP to request medical records from my physician(s)

Clinical Qualifying Questions

(Heart & Diabetes (HMO SNP) Chronic Special Needs Plans Only)
If the answer is "Yes" to at least one of the questions, the candidate pre-qualifies for the condition

Diabetes

- Have you been told by a doctor that you have diabetes (too much sugar in the blood or urine)? ☐ Yes ☐ No ☐ Not sure
- Have you ever been prescribed or are you taking insulin or an oral medication that is supposed to lower the sugar in your blood? ☐ Yes ☐ No ☐ Not sure

Cardiovascular Disorders

- Have you ever been told by a doctor that you have coronary artery disease, poor circulation due to hardening of the arteries or poor veins? ☐ Yes ☐ No ☐ Not sure
- Have you ever had a heart attack or been admitted to the hospital for Angina (chest pain)? ☐ Yes ☐ No ☐ Not sure

Chronic Heart Failure

- Have you ever been told by a doctor that you have heart failure (weak heart)? ☐ Yes ☐ No ☐ Not sure
- Have you ever had problems with fluid in your lungs and swelling in your legs in the past, accompanied by shortness of breath, due to a heart problem? ☐ Yes ☐ No ☐ Not sure

PLEASE TURN OVER TO COMPLETE THE FORM ➡

Physician Currently Treating the Applicant for the Qualifying Disease

Primary Care Physician Currently Treating the Condition(s)

Physician Name _____

Physician Phone # _____

Other Treating Specialists _____

Physician Name _____

Physician Phone # _____

☐ I authorize for AHP to request medical records from my physician(s)

List all current Medications: _____

_____

_____

I acknowledge that by joining the Heart & Diabetes (HMO SNP), I am enrolling in a plan which offers special programs specifically designed to maintain or improve my health condition. I understand that I am required to make an appointment at an Alignment Healthcare Center to get my special care plan underway. At that time, a health care provider will also verify any prequalifying conditions.

Enrollee Signature _____ Date _____

Agent/Broker Name _____ Date _____

Agent/Broker Signature _____

Appointment scheduled at time of enrollment? ☐ Yes ☐ No

Date _____ Time _____ Location _____

Alignment Health Plan is an HMO, HMO POS and an HMO SNP plan with a Medicare contract. Enrollment in Alignment Health Plan depends on contract renewal. Heart & Diabetes (HMO SNP) is available to anyone who has chronic Diabetes Mellitus and or anyone who has been diagnosed with cardiovascular disease or chronic heart failure.