

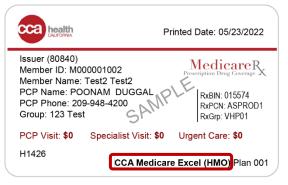
Instructions for Coverage Decision Request Form Supplemental Benefits for the Chronically III

Members with certain health conditions or adverse health outcomes may be eligible for additional benefits. We call these Special Supplemental Benefits for the Chronically III (SSBCI benefits). To qualify for SSBCI benefits, CCA Health California must document that you have an active qualifying chronic condition.

Please read these instructions carefully before you submit this form to us. You must complete all fields on the form and attach the required documentation. Forms that are received without the required information or documentation may result in a delay in processing, or a dismissal of your coverage request.

Your Health Plan

If you aren't sure which health plan you are enrolled in, check your member ID card. The plan type is located at the bottom of your member ID card.



Member ID or Medicare ID

Please provide your member ID number. If you are a new member, and you do not know your Member ID, you can provide us with the Medicare Number from your red, white and blue Medicare card.

Provider Information

Please tell us about the provider who diagnosed you, or the provider you see most often for treatment of your chronic illness. We may need to contact them about your coverage request. Knowing their contact information helps avoid delays in processing your coverage request.

Proof of qualifying condition(s)

Your coverage request for SSBCI benefits must include supporting documentation that you have an active qualifying chronic condition. Valid documentation must include your diagnosis, date of the diagnosis, provider name and their NPI number and contact information. You can find a list of qualifying conditions on the next page.

Supplemental Benefits for the Chronically III Qualifying Chronic Conditions

Autoimmune disorders limited to:	Chronic and disabling mental health conditions	Cardiovascular disorders limited to:	Cancer Excluding pre-cancer conditions or in-situ status		
 Polyarteritis nodosa Polymyalgia rheumatica Polymyositis Rheumatoid arthritis Systemic lupus erythematosus 	 Bipolar disorders Major depressive disorders Paranoid disorder Schizophrenia Schizoaffective disorder 	 Cardiac arrhythmias Coronary artery disease Peripheral vascular 	Chronic alcohol and other drug dependence		
		 disease Chronic venous thromboembolic disorder 	Chronic heart failure		
Chronic lung disorders	Severe hematologic disorders limited to:	Neurologic disorders limited to:	Dementia Including Alzheimer's		
 Asthma COPD Chronic bronchitis Emphysema Pulmonary fibrosis Pulmonary hypertension 	 Aplastic anemia Hemophilia Immune thrombocytopenic purpura Myelodysplastic syndrome Sickle-cell disease (excluding sickle-cell trait) Chronic venous thromboembolic disorder 	 Amyotrophic lateral sclerosis (ALS) Epilepsy Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) Huntington's disease Multiple sclerosis Muscular Dystrophy Parkinson's disease Polyneuropathy Spinal stenosis Stroke-related neurologic deficit 	Diabetes End-stage liver disease		
			HIV/AIDS		
			Stroke		



Coverage Decision Request Form Supplemental Benefits for the Chronically III

Submit this form with supporting documentation that you have an active qualifying chronic condition.

By Mail: CCA Health California	By Fax: 1-866-207-6539
Member Services Department	
2 Avenue de Lafayette, 5 th Floor	
Boston, MA 02111	

Your Health Plan

Select the health plan that you are a member of:

 \Box CCA Medicare Excel (HMO)

Member Information

Last Name:	First Name:	Middle Initial:
Member ID or Medicare ID:	Date of Bi	rth: / /
Home Phone:	Cell Phone: _	
Description of supporting docume	entation you are providing:	
Example: I am including a copy of a Use another sheet of p	a discharge summary from a rece diagnosis of diabetes. a per to include any additional	
Provider Information		
Provider Name:	Provider Pho	one:
Address:		
City:	State:	Zip Code:
Provider Fax:		

Sign Below

I understand that by submitting this form and my supporting documentation of a qualifying chronic condition, I am asking CCA Health California to make a Coverage Decision. A coverage decision is a decision we make about your benefits and coverage. We will review your request and your supporting documentation and send you a letter with our decision. In some cases, we might decide that the supporting information provided is insufficient for us to confirm that you have an active qualifying condition. If you disagree with the coverage decision, you will receive information explaining how to appeal our decision.

In limited circumstances, a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Print Name					
Signature:		Date:	/	/	
-	Member/Patient or Personal Representative*				

*If this form is being completed by an Authorized or Personal Representative, please print your name, phone number, and email in the section below. Check (\checkmark) the box that shows your legal authority under law to sign this form on the Member/Patient's behalf.

Please return this completed form with supporting documentation.

Personal/Authorized Representative Information					
First Name:		Last Name:			
Phone:		Email:		_	
□ HIPAA Agent/R	epresentative	□ Health Care Agent/Proxy	□ Other Advocate		
□ Attorney	□ Representative of Estate/Executor		□ Power of Attorney		
Guardian Conse	ervator				