

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

To qualify for SSBCI, the member must have one or more of the 10 active chronic conditions listed on this form. The member must also meet the following criteria to be eligible for SSBCI benefits:

- The condition is life-threatening or greatly limits overall health or function.
- The member is at high risk of hospitalization or other adverse health outcomes.
- The member requires intensive care coordination.

The plan will review objective criteria to determine a member's eligibility. Eligibility for SSBCI cannot be guaranteed based solely on your patient's conditions.

To qualify for the SSBCI benefit, the member must meet all applicable requirements.

Providers must submit this form to certify that the patient satisfies SSBCI eligibility requirements.

Patient name:	Date of birth:	Member ID:
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Patient Eligibility Prong 1

1. Has the patient been diagnosed with one or more of the qualifying conditions? ☐ Yes ☐ No

Qualifying conditions	
☐ Cardiovascular disorders ☐ Chronic and disabling mental health conditions ☐ Chronic gastrointestinal disease ☐ Chronic lung disease ☐ Congestive heart failure	☐ Connective tissue disease ☐ Dementia ☐ Diabetes ☐ Overweight, obesity, and metabolic syndrome ☐ Stroke
Other known conditions:	

Patient Eligibility Prong 2

2. Has the patient satisfied one or more of the following criteria? ☐ Yes ☐ No

Additional qualifying parameters (must have happened within the last 12 months):

- ☐ Had one or more inpatient admissions (inclusive of behavioral health) related to the chronic condition
- ☐ Had one or more urgent care or ER visits related to the chronic condition
- ☐ Had two or more outpatient visits related to the chronic condition (including primary care or specialty care visits)
- ☐ Requires home health visits related to the chronic condition
- ☐ Has one or more chronic conditions and a need for one or more pieces of durable medical equipment in the outpatient setting, limited to Group 3 power/manual wheelchair, noninvasive ventilation (NIV), BiPAP machine, mechanical in-exsufflation device, or Group 2 or Group 3 mattress

Provider name:	Provider NPI:
Date functional status review completed:	Signature and credentials of provider:

Please return a copy of the completed form to our Member Services team via one of the following;

Fax: **1-844-479-2802**

Mail: SSBCI, P.O. Box 7444, London, KY 40742-74444

Email: **SSBCI-PA@amerihealthcaritas.com**

Keep a copy in your patient chart or EMR. Review and update with your patient as needed.