Special Supplemental Benefits for the Chronically Ill (SSBCI)

Provider Attestation Form

Intended for use by:

Wellcare*, Wellcare by Absolute Total Care, Wellcare by Allwell, Wellcare by Buckeye Health Plan, Wellcare by Delaware First Health, Wellcare by Fidelis Care, Wellcare by Health Net, Wellcare by Meridian (IL), Wellcare by Meridian (MI), Wellcare by ʻOhana, Wellcare by Superior Health Plan

****see instructions on the last page for how to complete and submit****

*SSBCI is available only to Medicare Advantage Dual Special Needs Plans (DSNPs)
(except GA H0111004000 and CA H3561007000)

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Provider Attestation Form

Special Supplemental Benefits for the Chronically Ill (SSBCI)

To be completed and returned by a Provider or Provider Representative.

Fax this completed form to **1-844-743-1609**.

Note: For faster submission and processing, submit the information directly at **ssbci.rrd.com**.

*Indicates Required Fields

Member Information

***Member First Name:**	***Member Last Name:**
***Member ID:** *(Full ID as it appears on the Member ID card. Do not include dashes)*	***Member Language Preference (If other than English):** ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Korean ☐ Albanian ☐ Other _____ ☐ Tagalog
***Date of Birth:**	

Provider Information

By signing below, I certify that the above referenced patient has been evaluated against the defined criteria below and will submit a claim with appropriate diagnosis codes.

***Provider First Name:**	***Provider Last Name:**	
***Provider Representative:**	***Provider Email:**	
***Street Address:**		
***City:**	***State:**	***Zip:**
***Phone Number:**	***Fax Number:**	
***Provider NPI:**	**Facility Name:**	

To be completed by a Provider or Provider Representative:

I certify that the patient: (Please choose one response for all three criteria)	
1. ☐ Does require intensive care management	☐ Does **NOT** require intensive care management
2. ☐ Is at high risk for unplanned hospitalization	☐ Is **NOT** at high risk for unplanned hospitalization
3. ☐ Does have a qualifying chronic condition **(You must select the condition below)**	☐ Does **NOT** have a qualifying chronic condition

(continued)

Qualifying Chronic Conditions:

Autoimmune disorders, limited to
- ☐ Polyarteritis nodosa
- ☐ Polymyalgia rheumatica
- ☐ Polymyositis
- ☐ Systemic lupus erythematosus
- ☐ Crohn's
- ☐ Multiple Sclerosis

Cancer
- ☐ Cancer

Cardiovascular disorders, limited to
- ☐ Cardiac arrhythmias
- ☐ Chronic venous thromboembolic disorder
- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Vascular disease
- ☐ Congenital Heart Disease
- ☐ Hypertension

Chronic alcohol or other substance use disorder
- ☐ Chronic alcohol or other substance use disorder

Chronic and disabling mental health conditions, limited to
- ☐ Bipolar disorders
- ☐ Major depressive disorders
- ☐ Paranoid disorder
- ☐ Schizophrenia
- ☐ Schizoaffective disorder

Chronic gastrointestinal disease
- ☐ Chronic gastrointestinal disorders
- ☐ Congenital malformations of digestive system
- ☐ Congenital anomalies of intestines and abdomen
- ☐ Chronic gastrointestinal disease

Chronic heart failure
- ☐ Chronic heart failure

Chronic lung disorders, limited to
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Pulmonary fibrosis
- ☐ Pulmonary hypertension
- ☐ Cystic Fibrosis
- ☐ COPD (Chronic Obstructive Pulmonary Disease)

Conditions that require continued therapy services in order for individuals to maintain or retain functioning, limited to
- ☐ Muscular Dystrophy

Conditions with Cognitive Impairment, limited to
- ☐ Down Syndrome

Conditions with functional challenges, limited to
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Liver Conditions
- ☐ End-stage liver disease
- ☐ End-stage renal disease (ESRD) requiring dialysis

Dementia
- ☐ Dementia/Alzheimer's

Diabetes mellitus
- ☐ Diabetes mellitus (also known as Diabetes Type I or Type II)

Endometriosis
- ☐ Endometriosis

HIV/AIDS
- ☐ HIV/AIDS

Neurologic disorders, limited to
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Epilepsy
- ☐ Extensive paralysis (hemiplegia, quadriplegia, paraplegia, monoplegia)
- ☐ Huntington's disease
- ☐ Multiple sclerosis (MS)
- ☐ Parkinson's disease
- ☐ Polyneuropathy
- ☐ Spinal stenosis
- ☐ Stroke-related neurologic deficit
- ☐ Progressive Neurological Disease
- ☐ Polio
- ☐ Fibromyalgia
- ☐ Cerebral Palsy

Overweight, obesity, and metabolic syndrome, limited to
- ☐ Hyperlipidemia
- ☐ Morbid or Severe Obesity
- ☐ Dyslipidemia

Post-organ transplantation
- ☐ Post-organ transplantation

Severe hematologic disorders, limited to
- ☐ Aplastic anemia
- ☐ Chronic venous thrombocytopenic disorder
- ☐ Hemophilia
- ☐ Immune thrombocytopenic purpura
- ☐ Myelodysplastic syndrome
- ☐ Sickle-cell disease (excluding sickle-cell trait)

Stroke
- ☐ Stroke

***Signature of primary care provider/treating physician/specialist:**	***Date:**

This form verifies SSBCI eligibility only and does not guarantee benefit approval. Coverage is subject to plan terms, CMS guidelines, and contract renewal.

Instructions – How to Complete and Submit This Form

- Use this Special Supplemental Benefits for the Chronically Ill (SSBCI) Provider Attestation Form when a member has been diagnosed with a qualifying chronic condition and meets all SSBCI eligibility criteria.
- Members approved through this attestation may receive access to SSBCI services, which may include healthy food, rent and utility assistance, gas (pay at the pump), home assistance and safety items, and pest control items and services.
- Members are continuously reviewed through our weekly automatic eligibility process, which uses available claims data and is the fastest/most efficient way to determine SSBCI eligibility.
- In some cases, primarily for new members without sufficient claims history, a provider attestation may be used to support the eligibility review. Submission of an attestation does not guarantee approval, as eligibility is based on whether the member meets all required SSBCI criteria.

Step 1: Complete the Form

- This form may be completed by a healthcare provider or a provider representative.
- **Complete all required fields, indicated by an asterisk (*).**
- The provider must evaluate the member against all three SSBCI eligibility criteria:
  - **The patient must have a qualifying chronic condition** (that is life threatening or significantly limits overall health or function).
  - **The patient requires intensive care management** (patient must have frequent use of outpatient services or specialty care and/or, evidence of poor disease control or medication adherence and/or, social or behavioral factors impacting health outcomes).
  - **The patient is at high risk for an unplanned hospitalization** (patient has a history of frequent hospitalizations or ED visits related to the qualifying chronic condition).

Step 2: Provider Certification

- The provider must certify whether the member meets or does not meet the eligibility criteria.
- The form must be signed and dated to be considered complete.
- By signing, the provider attests that the member has been evaluated using the criteria outlined on this form and that a claim will be submitted with appropriate diagnosis codes.

Step 3: Submit the Completed Form

- Submit the completed and signed form via Fax: **1-844-743-1609**.
- Illegible or incomplete submissions may result in processing delays.

Processing Timeframes

- Within 14 business days of receipt of successful submission
- Providers will be contacted only if the form cannot be processed.
- Expedited processing requests cannot be accommodated.

Member Notification

- Members who meet all three eligibility criteria will be approved for SSBCI benefits.
- Members will be notified of approval or denial by letter within 14 business days after successful submission.