

SPECIAL NEEDS PLAN (SNP) PRE-QUALIFICATION FORM



Tell Us About Yourself (Please Print)

Member Name _____	Date _____	
Member DOB _____	Member Number/Medicare Beneficiary Identifier (MBI) _____	
Member Address _____		
City _____	State _____	
Zip Code _____	County _____	Member Phone # _____
Member Emergency Contact _____		
Member Emergency Contact Phone # _____		
Do you consider yourself to be homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Physician Currently Treating the Applicant for the Qualifying Disease

Primary Care Physician/Nephrologist/Dialysis Facility Currently Treating the Condition(s)
Physician Name _____
Physician Phone # _____
Other Treating Specialists _____
Physician Name _____
Physician Phone # _____
<input type="checkbox"/> I authorize for AHP to request medical records from my physician(s)

Clinical Qualifying Questions

(Special Needs Plan (SNP) 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
• Have you ever had a heart attack or been admitted to the hospital for Angina (chest pain)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Chronic Heart Failure	
• Have you ever been told by a doctor that you have heart failure (weak heart)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
End Stage Renal Disease (ESRD)	
• Are you currently undergoing Peritoneal dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
• Are you currently undergoing Hemodialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

PLEASE TURN OVER TO COMPLETE THE FORM →

List all current Medications: _____

I acknowledge that by joining a Special Needs Plan (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, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada and North Carolina Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Alignment Health Plans HMO C-SNP plans are available to anyone who has chronic Diabetes Mellitus and or anyone who has been diagnosed with cardiovascular disease or chronic heart failure.