Sentara® Health Plans

# Sentara Medicare Engage – Lung (HMO C-SNP) C-SNP member pre-enrollment qualification assessment tool (PQAT)

**Members**
This document must be completed if you are enrolling in Sentara Medicare Engage - Lung. Enrollment in a C-SNP is limited to individuals with at least one qualifying severe or disabling chronic condition. If you have at least one of the conditions listed below, you may be eligible for enrollment in Sentara Medicare Engage - Lung.

Once you fill in the 'Applicant information' section, you can submit this form by:

1. Taking it to your provider to sign and they will submit it to Sentara Medicare.
2. Submitting it with your enrollment form and Sentara Medicare will submit it to your provider for their signature.

If you need assistance completing this form or have any questions, please contact Sentara Medicare at **1-888-460-8129 (TTY: 711)**
October 1 -March 31 | 7 days a week | 8 a.m. -8 p.m. or
April 1 -September 30 |Monday -Friday | 8 a.m. -8 p.m.

**Providers**
You are receiving this form because the individual listed below identified themselves as your patient and has elected to enroll into the Sentara Medicare Engage - Lung plan. If the individual is not your patient, please contact us directly so we can update our records.

To be eligible for enrollment into the Sentara Medicare Engage - Lung plan, your patient must have one of the qualifying chronic conditions listed below.

The Centers for Medicare and Medicaid Services require Sentara Medicare to obtain confirmation from you within the first 30 days of coverage that your patient has been diagnosed with one of the qualifying conditions. If we do not obtain such confirmation, we are required to disenroll your patient from our C-SNP. We want to ensure your patient remains covered by Sentara Medicare. Fax this completed form to **(757) 648-1367** or **1-833-459-0789**.

| **Applicant information** | | |
|---|---|---|
| Last name: | First name: | MI: |
| Medicare ID: | Date of birth: | |
| Phone number: | Cell phone number: | |
| ☐ By checking this box, you authorize Sentara Medicare and its affiliates to send you text messages with information related to your health plan. | Email address: _____<br>☐ By checking this box, you authorize Sentara Medicare and its affiliates to send you messages with information related to your health plan by email. | |

| **Applicant information continued** | |
|---|---|
| **Healthcare provider(s) who can verify your chronic condition(s):** | |
| **Provider #1 name:** | Provider phone number: |
| Provider fax number: | Provider address: |
| **Provider #2 name:** | Provider phone number: |
| Provider fax number: | Provider address: |

**Authorization for use and disclosure of health information to verify chronic condition(s):**

I authorize the providers listed above to share my health information with Sentara Medicare and its affiliates to verify that I have a chronic condition that qualifies me for enrollment in Sentara Medicare Engage – Lung. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) I have marked above. I understand I may withdraw this consent at any time by contacting Sentara Medicare as indicated above. **I understand that if Sentara Medicare is unable to obtain confirmation of the chronic condition(s) during the first month of my enrollment, Sentara Medicare will notify me that I will be disenrolled from the C-SNP at the end of the second month of my enrollment.**

Applicant (or authorized representative) signature: _____

Date: _____

**To be completed by provider:**
**Please verify the patient's qualifying chronic condition(s). (Check all that apply):**

- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema
- ☐ Pulmonary fibrosis
- ☐ Pulmonary hypertension

**Healthcare provider attestation (can be completed by office staff or treating provider).**
**I hereby attest that the above information is correct and agree to provide supporting medical information to Sentara Medicare.**

| Printed name: | Title: |
|---|---|
| Signature: | Date: |

**To be completed by Sentara Medicare:**

Check applicable box and complete.

☐ Assessment was completed during face-to-face interview:

Date: _____ Time: _____

☐ Assessment was completed telephonically:

Date: _____ Time: _____

☐ Assessment was received by mail:

Date of receipt: _____