Sentara Health Plans

Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP)
C-SNP member pre-enrollment qualification assessment tool (PQAT)

This document must be completed if you are enrolling in Sentara Medicare Engage – Diabetes and Heart (HMO C-SNP). 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 – Diabetes and Heart. Please submit this completed form with your enrollment application.

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.

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: _____ ☐ By checking this box, you authorize Sentara Medicare and its affiliates to send you messages with information related to your health plan by email.	

Please verify you have been told by a licensed healthcare professional you have at least one of the following conditions (Check all that apply):

☐ **Cardiovascular disorders**

☐ **Chronic heart failure**

☐ **Diabetes** (type 1 or type 2)

Please provide a response to the questions below for the conditions marked in the previous section:

Cardiovascular disorder

1. Have you had a stroke or heart attack? ☐ Yes ☐ No
2. Have you been seen by a physician for the following or experienced:
   - a. Chest pain or discomfort ☐ Yes ☐ No
   - b. Swelling or a clot in an extremity ☐ Yes ☐ No
   - c. Palpitations, irregular heartbeat, fainting ☐ Yes ☐ No

Chronic heart failure

1. Have you been told by your doctor that you have congestive heart failure (CHF)? ☐ Yes ☐ No
2. Have you been seen by a physician for the following or experienced:
   - a. Shortness of breath at rest or with walking short distances ☐ Yes ☐ No
   - b. Swelling in the legs, ankles, or feet ☐ Yes ☐ No
   - c. Using additional pillows to sleep ☐ Yes ☐ No

Please provide a response to the questions below for the conditions marked in the previous section:

Diabetes (type 1 or type 2)

1. Have you been told by your doctor that you have diabetes? ☐ Yes ☐ No
2. Do you measure your blood sugar every day? ☐ Yes ☐ No
3. Do you take medications for your blood sugar? ☐ Yes ☐ No
4. Have you been admitted to the hospital for high or low blood sugar? ☐ Yes ☐ No

Please list the current medications you take for the conditions above:

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 – Diabetes and Heart. 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 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: _____