Sentara Health Plans

Sentara Medicare – SSBCI Chronic condition verification form

Dear Provider,

Your patient has applied for our monthly grocery allowance benefit. They have self-attested to one of the below chronic conditions to receive this benefit. We are required to show proof of their chronic condition diagnosis from their treating physician.

Please fill out this form and email it to Sentara Health Plans at SSBCI@sentara.com.

Please complete this verification within 48 hours of receipt.

Patient information		
Last name:	First name:	MI:
Medicare ID:	Date of birth:	

Please verify the patient's qualifying chronic condition(s). (Check all that apply):

- ☐ Chronic alcohol and other drug dependence
- ☐ Certain autoimmune disorders
- ☐ Cancer, excluding pre-cancer conditions
- ☐ Certain cardiovascular disorders
- ☐ Chronic heart failure
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ End-stage liver disease
- ☐ End-stage renal disease (ESRD) requiring dialysis (all models of dialysis)
- ☐ Certain severe hematologic disorders
- ☐ HIV/AIDS
- ☐ Certain chronic lung disorders
- ☐ Certain chronic and disabling mental health conditions
- ☐ Certain neurologic disorders
- ☐ Stroke

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:

Health plan office use ONLY		
Date received:	Health plan rep:	Status: