

To be completed by the primary care provider/treating physician/specialist.

I, _____,
(primary care provider/treating physician/specialist)

hereby certify that _____ has the following health condition(s):
(member)

<input type="checkbox"/> Chronic alcohol use disorder or other substance use disorders	<input type="checkbox"/> Dementia	<input type="checkbox"/> Chronic and disabling mental health conditions limited to bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia and schizoaffective disorder
<input type="checkbox"/> Autoimmune disorders limited to polyarteritis nodosa, polymyalgia rheumatica, polymyositis, rheumatoid arthritis and systemic lupus erythematosus	<input type="checkbox"/> Diabetes mellitus	
<input type="checkbox"/> Cancer, excluding precancer conditions or in situ status	<input type="checkbox"/> End-stage liver disease	
<input type="checkbox"/> Cardiovascular disorders limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder	<input type="checkbox"/> End-stage renal disease (ESRD) requiring dialysis	<input type="checkbox"/> Neurologic disorders limited to amyotrophic lateral sclerosis, (ALS), Epilepsy, extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, multiple sclerosis, Parkinson's disease, polyneuropathy, spinal stenosis and stroke-related neurologic deficit
<input type="checkbox"/> Chronic heart failure	<input type="checkbox"/> Severe hematologic disorders limited to aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease (excluding sickle-cell trait) and chronic venous thromboembolic disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> None	<input type="checkbox"/> HIV/AIDS	
If none: <input type="checkbox"/> Member not seen <input type="checkbox"/> No chronic condition	<input type="checkbox"/> Chronic lung disorders limited to asthma, chronic bronchitis, emphysema, pulmonary fibrosis and pulmonary hypertension	

Onset Date of Health Condition(s):	
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Signature of primary care provider/treating physician/specialist

Date		Phone	
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Member Information

Member Name			
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Date of Birth		Medicare ID Number (MBI/HICN)	
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