Allwell (HMO SNP)

Pre-enrollment Qualification Assessment Tool

Allwell is a Medicare Advantage Special Needs Plan (SNP) designed for people with chronic conditions such as diabetes or chronic heart failure.

Enrollee information

Last name: First name: MI:

Medicare number: Phone number: – –

Birth date:

M M D D Y Y Y Y

Please complete and submit this form with your enrollment application. If you can answer "Yes" or "Not sure" to any of the following questions, you may be eligible to join our chronic care SNP. When this form is completed and submitted along with an enrollment application, you will be enrolled into Allwell. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from the Special Needs Plan.

Chronic condition questions

Have you been diagnosed with diabetes? ☐ Yes ☐ No ☐ Not sure

Have you had problems with high blood sugar? ☐ Yes ☐ No ☐ Not sure

Do you take medication and/or have you been put on a special diet to control your blood sugar? ☐ Yes ☐ No ☐ Not sure

Have you been diagnosed with chronic (or congestive) heart failure (CHF)? ☐ Yes ☐ No ☐ Not sure

Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem? ☐ Yes ☐ No ☐ Not sure

Do you take medication to prevent fluid retention? ☐ Yes ☐ No ☐ Not sure

Have you been diagnosed with any of the following cardiovascular disorders? ☐ Yes ☐ No ☐ Not sure

- Cardiac arrhythmia
- Chronic venous thromboembolic disorder
- Coronary artery disease
- Peripheral vascular disease

Have you had problems with rapid, erratic heartbeats? ☐ Yes ☐ No ☐ Not sure

Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke? ☐ Yes ☐ No ☐ Not sure

Has a physician ever told you that you have a blood clot? ☐ Yes ☐ No ☐ Not sure

(continued)

Health care provider(s) who can verify your chronic condition(s)

PROVIDER #1

Provider name:

Provider address:

Provider phone: – –

Provider fax: – –

PROVIDER #2

Provider name:

Provider address:

Provider phone: – –

Provider fax: – –

Authorization for Disclosure of Health Information to Verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the providers listed above to Allwell in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in Allwell Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Information disclosed as a result of this authorization will be protected by Allwell in accordance with applicable state and federal laws and requirements.

Signature

Enrollee signature:

Date: M M D D Y Y Y Y

Broker/Agent name (if applicable):

Broker/Agent signature (if applicable):

Date: M M D D Y Y Y Y

For more information or for assistance with this form, please call Member Services at 1-800-977-7522 (TTY: 711)

Hours of operation: From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

Allwell is contracted with Medicare for HMO SNP plans. Enrollment in Allwell depends on contract renewal.

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