Eligibility Verification Form

The plan that you have selected is designed to meet the needs of people who have diabetes and/or congestive heart failure (CHF). Please fill out and return this form to help us verify your condition.

_______________________________________________________   __________________________________
Customer name Date of birth

Medicare ID # (if known) __________________________________  Gender □ Male □ Female

DIABETES (HIGH BLOOD SUGAR) VERIFICATION
“Yes” to questions 1 or 2 automatically prequalifies you.
1. Has your doctor diagnosed you with diabetes (high blood sugar)? .................................................. □ Yes □ No
2. Are you currently taking prescription medication for diabetes (high blood sugar)? .............. □ Yes □ No

CONGESTIVE HEART FAILURE (CHF) VERIFICATION
“Yes” to questions 1 or 2 automatically prequalifies you.
1. Has your doctor diagnosed you with congestive heart failure (CHF)? ............................... □ Yes □ No
2. Are you currently taking prescription medication for congestive heart failure (CHF)? ............. □ Yes □ No

Please list the provider(s) familiar with your diabetes or congestive heart failure (CHF) treatment. This may be your primary care physician (PCP) or the doctor who diagnosed you with diabetes or congestive heart failure (CHF):

___________________________________________   __________________________________________
Provider name Provider name

___________________________________________   __________________________________________
Provider phone # Provider phone #

___________________________________________   __________________________________________
Provider fax # Provider fax #

___________________________________________   __________________________________________
Provider address Provider address

ONL Y COMPLETE THIS FORM IF YOU ARE ENROLLING IN THE DIABETES HEART PLAN
I, (applicant name) ____________________________________________, hereby authorize the disclosure of my health information by the providers listed above to Cigna in order to verify that I have been diagnosed with diabetes mellitus or congestive heart failure (CHF), thus qualifying me for enrollment in the Cigna Medicare Select Plus Rx – Diabetes Heart plan. This authorization applies to all health information maintained by the Provider concerning my medical history or care from (insert date) _____________________ to present for the condition indicated above. This authorization will expire upon the earlier of: (i) my not enrolling in the Cigna Medicare Select Plus Rx – Diabetes Heart plan; or (ii) the termination of my enrollment in the Cigna Medicare Select Plus Rx – Diabetes Heart plan.

I understand the following:

• I may cancel this authorization at any time prior to my enrollment in the Cigna Medicare Select Plus Rx Diabetes Heart plan. My cancellation must be in writing, signed by me or by my authorized representative, and sent to Cigna. My cancellation will be effective upon receipt by Cigna, but will not be effective to the extent that Cigna or others have already acted in reliance upon this authorization.

• I understand that if I refuse this authorization, Cigna may reject my enrollment.

• Information disclosed as a result of this authorization will be protected by Cigna in accordance with applicable state and federal confidentiality laws and requirements.

___________________________________________   __________________________________________
Print name of applicant/enrollee/authorized rep. Medicare ID

___________________________________________   __________________________________________
Signature of applicant/enrollee/authorized rep. Date

___________________________________________   __________________________________________
Print name of sales agent Agent ID #

If you are the authorized representative of the applicant, you must provide the following information:

___________________________________________   __________________________________________
Name Relationship

___________________________________________   __________________________________________
Address Telephone

This information is available for free in other languages. Please call our Customer Service number at 1-855-561-3811 for additional information. (TTY users should call 711). Hours are 8 am to 8 pm MST, 7 days a week (Monday through Friday, February 15 – September 30, 2014). Customer Service also has free language interpreter services available for non-English speakers.

Esta información es disponible gratuitamente en otros idiomas. Si necesita información adicional por favor hable al departamento del Servicio al Miembro al 1-855-561-3811. (Los usuarios de TTY/TDD deben llamar al: 711). Los horarios son de 8 a.m. a 8 p.m., hora estándar de la montaña, los 7 días a la semana. (Del 15 de Febrero al 30 de Septiembre 2014). El departamento del Servicio al Miembro tiene servicios gratis de intérprete disponible para no-Inglés oradores.

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