Additional Benefit Verification Form

In order to receive additional transportation to plan approved locations like places of worship or community centers, your plan requires that your health condition(s) be verified by your primary care provider or treating physician's office.
This is a 2-part process:

1. Select your health conditions(s) below, sign and complete the information requested on page 2 under APPLICANT so that we can have your provider verify your condition(s). Call the number at the bottom of page 2 if you have any questions.
2. Send your completed form. We will use the form to have your provider confirm your condition(s).

To be completed by the applicant or by authorized legal representative

Name: _____

DOB: _____ **Medicare ID (MBI/HICN):** _____

Qualifying clinical conditions

This is a pre-assessment, final verification will be completed with your provider.

Please select the health condition(s) that apply to you:

- ☐ Autoimmune disorders
- ☐ Cancer (excluding pre-cancer conditions or in-situ status)
- ☐ Cardiovascular disorders
- ☐ Chronic alcohol or other drug dependence
- ☐ Chronic and disabling mental health conditions
- ☐ Chronic heart failure
- ☐ Chronic kidney disease (stage 3 – moderate)
- ☐ Chronic lung disorders
- ☐ Dementia
- ☐ Diabetes mellitus
- ☐ End-stage liver disease
- ☐ End-stage renal disease (ESRD) requiring dialysis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Morbid obesity
- ☐ Neurological disorders
- ☐ Protein-calorie malnutrition
- ☐ Severe hematologic disorders
- ☐ Spinal cord disorders or injuries
- ☐ Stroke

Applicant/authorized representative: _____

Completing this pre-assessment does not affect enrollment in the plan. This plan requires verification from a provider or specialist in order to receive additional transportation to plan approved locations like places of worship or community centers.

Additional Benefit Release of Information Form

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with federal law concerning the privacy of such information.

Use and disclosure authorization

APPLICANT, please complete (* indicates required field).

I, *(insert applicant name)* _____ , hereby authorize the disclosure of my health information described above by:

Name of provider (last name, first name)*	Provider telephone number*
Provider address*	
City*	State* / ZIP code*

Applicant date of birth: _____

Applicant/authorized representative signature **Today's date**

_____

CARE PROVIDER/SPECIALIST, please complete.

I, _____ (Primary care provider/specialist/care provider representative), hereby certify that _____ (applicant) has the health condition(s) as noted on the front page.

Primary care provider/treating physician/specialist signature **Today's date**

_____

Please send the completed forms to:

UnitedHealthcare
1 East Washington St, Suite 900
Phoenix, AZ 85004
Attn: Member Services

Or fax the front and back of each page to:
855-250-2099

If you have any questions, please call:
866-522-0629, TTY **711**,
Monday–Friday 8 a.m.–5 p.m. local time

UHCCP_Attestation@uhc.com

The additional transportation to plan approved locations like places of worship or community centers benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as high blood pressure, high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Contact us for details.