Chronic Special Needs Plan (CSNP) Verification Form

Patient Name: **DOB:**

Patient Identification:

Diagnosis:

I confirm that the member stated above has been diagnosed with and/or under treatment for one or more of the following chronic conditions:
**If a doctor is not available to sign the form, please fax patients' problem list within the last calendar year. **

Please check all that apply

- ☐ **Diabetes- Anthem/Wellpoint Chronic Care**
- ☐ **COPD, Asthma, Chronic Bronchitis, Emphysema, Pulmonary Fibrosis- Anthem/Wellpoint Lung Care**
- ☐ **Chronic Heart Failure (CHF), Pulmonary Hypertension, Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder, Pulmonary Embolism, Deep Vein Thrombosis, Old Myocardia Infarct, Atrial Fibrillation- Chronic Care**
- ☐ **End Stage Renal Disease (ESRD)**
- ☐ **Patient did not present with any of the diagnosis listed above**

Signature:_____ MD/DO/NP Date:_____

Print or stamp Name_____

Please return the completed form within 5 days of receipt via fax or email to:

Elevance Health Anthem/AmeriGroup Membership Department
Fax: 855 503-2573