Verification of Chronic Condition (VCC)

The member listed below has enrolled in a Humana Medicare Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to Humana right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name: _____ Date of Birth: _____

Address: _____

Humana ID: _____ Medicare ID: _____

Proposed Effective Date: _____

My signature below authorizes information about my chronic condition to be shared with Humana. Note: While Humana does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

To Be Completed by the Physician/Physician's Office

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

- ☐ None
- ☐ Diabetes
- ☐ Chronic Heart Failure
- ☐ End Stage Renal Disease, requiring dialysis
- ☐ Chronic Lung Disease: Asthma, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension
- ☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Chronic Venous Thromboembolic Disorder

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to Humana:

- Via the **Availity** provider portal, or
- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **VCC@humana.com,** or
- Call us at **1-877-271-5229** to provide verbal verification.
- (Monday – Friday, 8 a.m. to 6 p.m., Eastern time)