MedCare Partners
Health Plan of Texas

Care | Connection | Community

Helping You Live Healthier. Longer.

Provider Verification Form

To qualify for a Chronic Care Specials Needs Plan (C-SNP), members must have a qualifying condition.

Please complete and return this form to:

Fax: 888-207-0789
Email: <need email address>
Questions: 1-866-MCPTX01 (1-866-627-8901)

1. MEMBER INFORMATION

Member First Name:	Member Last Name:
Member ID:	Date of Birth (MM/DD/YYYY):

Plan Name: ☐ MedCare Focus (C-SNP) ☐ MedCare Choice (C-SNP)

2. QUALIFYING CHRONIC CONDITION

Please check the member's qualifying condition. The member must have at least one of the conditions below to be eligible.

☐ **Diabetes**

☐ **Chronic heart failure**

☐ **Cardiovascular disorders** (e.g., arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder)

3. PROVIDER ATTESTATION

☐ **I attest that the above-named member has the qualifying chronic condition checked above.**

☐ **I attest that the above-named member does not have any of the above qualifying chronic condition.**

Provider Name (Please Print):	Title:
Practice Name:	Phone:
Provider Signature:	Date (MM/DD/YYYY):

Important:

- This form must be completed and signed by the member's treating provider (MD, DO, NP, or PA).
- Having a qualifying condition does not automatically guarantee the benefit. Final eligibility is determined by MedCare Partners Health Plan of Texas in accordance with CMS requirements.
- Please return this form using the fax or email information above.