UnitedHealthcare®

Chronic Condition Verification 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

CARE PROVIDER/SPECIALIST, please complete.

I,________________________________ (Care Provider/Specialist/Care Provider Representative),

hereby certify that ____ (Applicant)

has the following health condition(s):

☐ **Diabetes** ☐ **Chronic Heart Failure** ☐ **Cardiovascular Disorders**

Care Provider/Specialist Signature: ____________________________ **Date:** MM/DD/YYYY

APPLICANT, please complete if applicable.

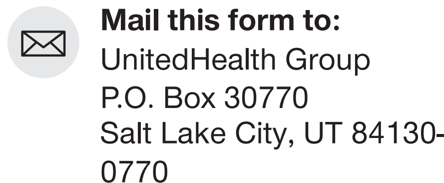
Print Name of Applicant/Authorized Representative	Medicare ID Number or Date of Birth

Signature of Applicant/Authorized Representative	Date

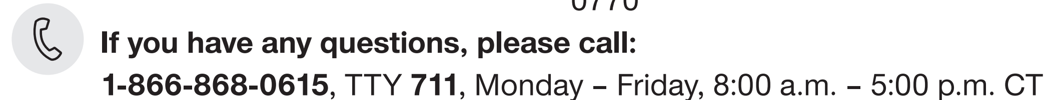
If you are the authorized representative of the applicant, please provide the following information:

Relationship to Applicant	Address	Telephone Number
		___-___-____

Fax this form to:
1-888-950-1170



Mail this form to:
UnitedHealth Group
P.O. Box 30770
Salt Lake City, UT 84130-0770



If you have any questions, please call:
1-866-868-0615, TTY **711**, Monday – Friday, 8:00 a.m. – 5:00 p.m. CT

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan's contract renewal with Medicare.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894（TTY：711).

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Doc#: PCA-1-002276-06142016_06282016 UHTX17CH3868155_001