
Form Instructions

To qualify for SSBCI, your patient must be a chronically ill individual who has one or more of the five active qualifying chronic conditions listed on the next page and **meet all of the following**:

- 1) is life threatening or significantly limits the overall health or function of the individual; and
- 2) has a high risk of hospitalization or other adverse health outcomes; and
- 3) requires intensive care coordination.

Eligibility for SSBCI cannot be guaranteed based solely on your patient's conditions. All applicable eligibility requirements must be met before the benefit is provided.

Please complete this **Provider Attestation of Patient Diagnosis for SSBCI Eligibility** attesting that the patient meets the above criteria and documenting the qualifying conditions the patient has been diagnosed with in the past 12 months. Then, **fax** the completed form and supporting documentation to **1-877-531-0080 or mail them to:**

eternalHealth
Care Management Department
31 St. James Ave, Suite 950
Boston, MA 02116

ALL FIELDS MUST BE COMPLETED

Patient Information

First Name: _____ Last Name: _____ MI: _____

eternalHealth Member ID: _____ Date of Birth: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Provider Attestation

- ☐ My records for the above-named patient document diagnoses of a chronically ill individual who has one or more of the five active qualifying chronic conditions selected below and meet all of the following:
- 1) is life threatening or significantly limits the overall health or function of the individual; and
 - 2) has a high risk of hospitalization or other adverse health outcomes; and
 - 3) requires intensive care coordination.

The active qualifying chronic conditions selected below apply:

- | | |
|--|--|
| ☐ Chronic and disabling mental health conditions | ☐ Cardiovascular disorders |
| ☐ Chronic kidney disease (CKD) | ☐ Cancer |
| ☐ Diabetes mellitus | |

Additional Qualifying Criteria

Answer both questions. Visits and stays must be **within the past 12 months**.

Criterion 2: High risk of hospitalization or other adverse health outcomes

Has the patient met one or both? (Check all that apply.) ☐ **Yes** ☐ **No**

- ☐ Had one or more inpatient admissions or observation stays (including behavioral health) related to the chronic condition
- ☐ Had one or more urgent care or ER visits related to the chronic condition

AND

Criterion 3: Intensive care coordination

Has the patient met one or both? (Check all that apply.) ☐ **Yes** ☐ **No**

- ☐ Requires intensive care coordination
- ☐ Has had multiple outpatient visits related to the chronic condition (including primary care or specialty care visits)

Supporting documentation required

Please submit documentation to support your responses, such as encounter records, progress notes, or acute stay notes. Fax it with this form to **1-877-531-0080**, or mail it to the address on page 1.

- ☐ My records for this patient do not include a diagnosis of any of the above conditions and/or the patient is not at high risk of hospitalization or other adverse health outcomes.

I hereby attest that the information selected above is correct and is noted in the patient's medical record.

Provider Name
(please print)

Provider Credential
(i.e., MD, NP, DO)

Provider NPI#

Provider Signature

Date

Phone: _____

Fax: _____

Address: _____

City: _____

State: _____

Zip Code: _____