

Physician Office Cover Letter

Your patient has applied to enroll in an Evercare® Health Plan for People with Specific Long-Term Illnesses. Centers for Medicare & Medicaid Services (CMS) requires that all health plans offering a chronic illness special needs plan verify that all applicants enrolling in that type of plan have been diagnosed with an eligible illness. This is not a process specific to Evercare. In accordance with these guidelines, we are required to verify the diagnosed chronic condition(s) of the applicant.

Applicants whose illness is not verified by his or her physician's office will be denied coverage.

Applicant Signature: _____ Date: _____

Applicant Name: _____

Applicant Address: _____

Applicant Medicare ID #: _____

Applicant Date of Birth: _____

Our applicant has authorized us to complete this verification process with your office. A copy of the Authorization for Use or Disclosure of Health Information is attached for your reference.

You or your office staff may complete this verification by:

1. Faxing the attached chronic condition identification form to **1-704-719-2703**.
(We are not requesting medical records.)
2. Contacting Evercare by telephone at **1-877-685-2385**, 8 a.m.–8 p.m. local time, 7 days a week. TTY users, call **711**.

In order to assist Evercare in complying with Medicare guidelines, please respond to this verification request within 3 days of receipt.

Evercare strives to protect our applicant's right to privacy. Please do not hesitate to contact us with any questions regarding this verification process.



Evercare Verification Unit
P.O. Box 6100
Eau Claire, WI 54702-9863
Phone: 1-877-685-2385
TTY: 711
8 a.m.–8 p.m., 7 days a week

Physician Office Verification – Fax Form

Please Note: Only this page needs to be faxed back to the Evercare Verification Unit

Physician office verification of chronic condition diagnosis

To: Evercare Verification Unit

Fax: 1-704-719-2703

Required: Patient/Applicant Name: _____

Patient/Applicant Medicare ID # : _____

has been diagnosed with the following chronic condition(s):

PLEASE CHECK ALL THAT APPLY: (We are not requesting medical records)

- Diabetes Mellitus
- Chronic Heart Failure
- Cardiac Arrhythmia
- Peripheral Vascular Disease
- Coronary Artery Disease (CAD)
- Chronic Venous Thromboembolic Disorder
- Patient does not have any of the above illnesses documented in his or her patient chart**

Required Information:

Physician Clinic: _____

Physician Clinic Tax ID: _____

Physician Clinic Phone #: _____

Physician Clinic Fax #: _____

Physician Name: _____

Staff member verifying illness: _____ Date: _____

Physician Clinics:

Please complete and return via confidential fax line at **1-704-719-2703** or call **1-877-685-2385**; TTY users, call **711**; 8 a.m.–8 p.m. local time, 7 days a week, to verify information telephonically. Thank you.

Agents:

Please contact the physician clinic to verify the applicant's illness, document ALL required information, sign attestation, and return via confidential fax line at **1-704-719-2703**.

I certify that ALL information provided on this form was provided by the indicated physician-clinic representative. I certify that the illness verification is truthful and accurate. I understand that providing fraudulent verification information will result in the termination of my contract with UnitedHealthcare Insurance Company, on behalf of itself and its Affiliates and will be reported to state and federal licensing agencies.

Agent ID: _____

Agent Name: _____

Agent Signature: _____

Date: _____