Zing Essential Wellness (HMO C-SNP). Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes Chronic Condition Verification

This attestation can be obtained verbally on a recorded phone line, through an encrypted email or faxed completed attestation form. You or your office staff may complete this verification.

PHONE: 1-866-946-4458 **FAX:** 312-809-9404 or 855-946-4458 **EMAIL:**enrollment@myzinghealth.com

***Please send via encrypted email to protect the patient's privacy**

Provider Name	
Phone	

You are receiving this notice because your patient has elected to enroll into the Zing Essential Wellness (HMO C-SNP) Medicare Advantage plan. If this is not a patient of yours, please contact us directly so we can update our records.

Within the enrollment application, he/she has released authorization for Zing Health to obtain this information from you.

To complete enrollment into a Chronic Special Needs Plan, your patient must prove that he/she has a qualifying chronic condition evidenced by one or more of the following: *Cardiovascular Disorders* (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic), *Chronic Heart Failure*, and/or *Diabetes* (Type I or Type II).

Zing Health will need confirmation from you within the enrollee's first 30 days of effective coverage that the enrollee has been diagnosed with one of the qualifying conditions. Your response is vital to ensure your patient remains covered by Zing Essential Wellness (HMO C-SNP).

Patient Information		
Last Name:	First Name:	MI:
Medicare ID:	Date of Birth:	
Please verify the patient's qualifying chronic conditions (Check all that apply)		
☐ Cardiovascular Disorders ☐ Chronic Heart Failure ☐ Diabetes (Type I or Type II)	☐ Patient does not have any of the chronic conditions documented in their chart.	
Healthcare Provider Attestation (can be completed by office staff or treating provider) ***I hereby attest that the above information is correct and noted in the patient's medical record.***		
Printed Name:	Title:	
Signature:	Date:	
Practice Stamp/Seal:		

Please complete verbal or written verification within 48 hours of receipt.

Health Plan Office Use ONLY		
Date Received:	Health Plan Rep:	Status: