



TIME-SENSITIVE: DO NOT DISCARD

ACTION REQUIRED: PATIENT ENROLLMENT VERIFICATION

Your patient's continued enrollment in a Medicare Chronic Condition Special Needs Plan (C-SNP) may depend on timely completion of the attached verification form.

Please note that:

- Your patient has authorized Zing to obtain this data from you within their enrollment application.
- Your patient is at risk of **disenrollment** if not verified within 60 days of their plan effective date.
- This form can be completed by the enrollee's provider or authorized office staff.

Instructions: Complete Sections B and C and return the form within 48 hours via fax (877-289-2295) or encrypted email (CSNPVerification@myzinghealth.com) to avoid a lapse in your patient's coverage.

If you are the intended recipient, please do not discard this fax without taking the requested action. If the individual is not your patient, please check the applicable box in Section B and return it so Zing Health can update its records.

Phone: 866-946-4458 | **Fax:** 877-289-2295

Email: CSNPVerification@myzinghealth.com

Confidentiality Notice: The information contained in this facsimile may be confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action is regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this coversheet along with its contents, and delete it from your system, if applicable.

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Provider Name			
Phone		Fax	

Your patient has enrolled in a Zing Health Medicare Advantage Chronic Condition Special Needs Plan (C-SNP). To complete enrollment, Zing Health is required to obtain verification of the diagnosis of one or more of the qualifying conditions listed below from his or her current healthcare provider.

Please note that:

- Your patient has authorized Zing to obtain this data from you within their enrollment application.
- Your patient is at risk of **disenrollment** if not verified within 60 days of their plan effective date.
- This form can only be completed by the enrollee's provider or authorized office staff.

Instructions: Complete Sections B and C and return the form within 48 hours via fax (877-289-2295) or encrypted email (CSNPVerification@myzinghealth.com) to avoid a lapse in your patient's coverage. If this is not your patient, please check the appropriate box in Section B so we can update our records.

Section A: Patient Information		
First Name:	Last Name:	MI:
Medicare ID:	Date of Birth:	
Section B: Patient's Chronic Conditions <i>(check all that apply)</i>		
☐ Cardiovascular Disorders <i>(limited to Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, and/or Valvular Heart Disease)</i>	☐ Metabolic Syndrome	
☐ Chronic Heart Failure	☐ Overweight <i>(BMI 25 - 29.9), or Obesity</i> <i>(BMI ≥ 30)</i>	
☐ Chronic Kidney Disease <i>(Stages 1-4)</i>	Non-Qualifying Options ☐ Above provider does not (or no longer) work here ☐ Patient does not have any of these conditions ☐ Patient is not (or no longer) under my care	
☐ Chronic Kidney Disease <i>(Stage 5; End Stage Renal Disease)</i>		
☐ Diabetes <i>(Type I or II)</i>		
Section C: Signer Information <i>(must be signed by provider or authorized office staff)</i>		
Printed Name:	Title:	
Signature:	Date:	
Practice Stamp/Seal:		