IMPERIAL HEALTH PLAN OF CALIFORNIA

Imperial Health Plan of California (HMO SNP) Pre-Enrollment Qualification Assessment Tool

This form must be submitted with the enrollment application for Imperial Health Plan of California (IHP) (HMO SNP) Senior Value plan 005.

Applicant to Complete		
First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female	DOB:	Phone Number:
Address:		
City:	State:	Zip

Clinical Qualifying Questions

If you have any of the following, you may be eligible to join IIHP plan 005. Prior to the end of the first month of enrollment, IHP will confirm with your assigned licensed practitioner that you have a qualifying condition necessary for enrollment in IHP Chronic SNP plan 005. If at any time, or at some subsequent time, it is determined you do not have a qualifying condition, you will no longer be eligible for IHP Chronic SNP plan 005 and IHP will be required to disenroll you from plan 005.

Check off the boxes for conditions your doctor has said you may have:

☐ **Diabetes Mellitus** (high blood sugar)

☐ **Chronic Heart Failure**

- ☐ Hypertension (high blood pressure)

☐ **Cardiovascular Disorder**

- ☐ Cardiac arrhythmias (palpitations, extra heart beats, atrial fibrillation, atrial flutter, fast or slow heart rate, pacemaker, defibrillator, fainting)
- ☐ Coronary artery disease (heart attacks, stents, heart surgery)
- ☐ Peripheral vascular disease (poor circulation)
- ☐ Chronic venous thromboembolic disorder (blood clots)
- ☐ History of stroke
- ☐ Hyperlipidemia (High cholesterol level)

Medication Questions

1. Are you now or have you ever taken medications for an illness listed above? ☐ Yes ☐ No
2. Have you ever been taken insulin Injections? ☐ Yes ☐ No
3. Have you ever taken Metformin? ☐ Yes ☐ No
4. What medications are you currently taking? _____

_____

Physician Name:	Phone Number:	Fax Number:
Physician Address:		

Applicant's Authorization to Disclosure Health Information

I hereby authorize the disclosure of my health information by the provider listed above to IHP to verify I have been diagnosed with a chronic condition which qualifies me for enrollment in IHP. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

_____	_____	_____
Print Name of Applicant	Signature of Applicant	Date

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Licensed Practitioner to Complete		
Physician Name:	Phone Number:	Fax Number:
Physician Address:		

I hereby confirm the above applicant has the qualifying chronic condition(s) indicated below.
Applicant has:

☐ **Diabetes Mellitus (**high blood sugar)

☐ **Chronic Heart Failure**

- ☐ Hypertension (high blood pressure)

☐ **Cardiovascular Disorder**

- ☐ Cardiac arrhythmias (palpitations, extra heart beats, atrial fibrillation, atrial flutter, fast or slow heart rate, pacemaker, defibrillator, fainting)
- ☐ Coronary artery disease (heart attacks, stents, heart surgery)
- ☐ Peripheral vascular disease (poor circulation)
- ☐ Chronic venous thromboembolic disorder (blood clots)
- ☐ History of stroke
- ☐ Hyperlipidemia (High cholesterol level)

_____	_____	_____
Print Name of Physician	Signature:	Date Applicant Seen:

Fax Assessment Tool to IHP at 1-626-380-9066 attention Membership Department

If you should have any questions please contact our Member Services Department at 1-800-838-8271, (TTY/TDD: 711), Monday through Sunday, 8:00 am to 8:00 pm except holidays during October 1 through March 31 and Monday through Friday 8:00 am to 8:00 pm April 1 through September 30 except holidays.

Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal.

Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-838-8271 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-838-8271 (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 1-800-708-5976 (TTY: 711).