1 Cameron Hill Circle
Chattanooga, TN 37402
bcbstmedicare.com

Dear <Doctor Name>,

Our Medicare Advantage Chronic Condition Special Needs Plan (C-SNP) is designed for people with diabetes, cardiovascular disorders and/or chronic heart failure who are enrolled in Medicare Parts A and B. Medicare requires us to have a provider attestation that <Prospective Member Name> has a formal diagnosis of diabetes mellitus, cardiovascular disorders and/or chronic heart failure. Please complete this simple attestation and return it to us by <30 days after member's effective date>. If we don't receive confirmation by this date, the member will be disenrolled from the C-SNP plan. Thank you, as always, for your help.

Sincerely,

Linda Pate MD
Vice President & Chief Medical Officer
Senior Products

Mail this form to:

BlueCross BlueShield of Tennessee
Attn: C-SNP Provider Attestations
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37402

Fax this form to:

(423) 535-1932

Complete this form online:

www.provider.circlecompare.ai/attestation

If you should have any questions, please call Member Outreach at **1-833-837-2583**, TTY **711**, Monday through Friday, 9 a.m. to 5 p.m. ET. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the Blue Cross Blue Shield Association

of Tennessee

BlueAdvantage Provider Attestation

Total Heart and Diabetes (PPO C-SNP)SM
Total Heart and Diabetes Plus (PPO C-SNP)SM

The individual below has indicated they're one of your patients. To qualify for continued enrollment, Medicare requires one of the individual's treating physicians to verify they've been diagnosed with the qualifying condition of diabetes, cardiovascular disorders, and/or chronic heart failure. Without this signed attestation, the individual must be disenrolled from the C-SNP plan. **Please submit this form no later than <30 days after member's effective date>.**

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Patient's Information

First Name: _____ Middle Initial: ___ Last Name: _____

Medicare Beneficiary Number: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Provider Information (Provider to complete)

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

of Tennessee

Provider Attestation (Provider to complete)

☐ **Yes, my records for this patient include a diagnosis of one or more of the following qualifying chronic conditions:**

- **Diabetes Mellitus**
- **Cardiovascular Disorders**
- **Chronic Heart Failure**

☐ **No, my records for this patient don't include a diagnosis of any of the above chronic conditions.**

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

Provider Printed Name	Provider Signature	Provider Signature Date