

PROVIDER ATTESTATION FORM

Special Supplemental Benefits for the Chronically Ill (SSBCI) – Medicare only

This form is used to attest that my patient meets the eligibility for SSBCI in accordance with Priority Health Medicare SSBCI Eligibility Policy and CMS requirements under 42 CFR § 422.102(f). This attestation serves as documentation supporting eligibility determination.

According to the Centers for Medicare & Medicaid Service (CMS) guidelines, to qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), the health plan member must have been diagnosed with one or more eligible chronic conditions and meet the following criteria:

1. The condition must be life-threatening or significantly limits overall health or function.
2. The individual must have a high risk of hospitalization or other adverse health outcomes.
3. Intensive care coordination is required.

Additionally, SSBCI benefits have a reasonable expectation of improving or maintaining the health or overall function of the member.

The following are the only Priority Health Medicare plans that offer the SSBCI items/services for calendar year 2027:

Plan names	SSBCI items/services
Priority Medicare Align (HMO-POS) Priority Medicare Latitude (HMO-POS)	Healthy food and produce
Priority Medicare D-SNP (HMO) Priority Medicare Dual Premier (HMO D-SNP)	Healthy food and produce, personal care items, household supplies, utilities, pest control, online meal delivery

Provider instructions for completion:

1. Sections 1-3: Fill out details pertaining to patient and provider information.
 - a. Fill out the required information in the provider information section.
2. Section 4: Complete provider attestation.
3. Submit the completed form.
 - Fax: 616.942.0616
 - Email: ***PH-DCC@PriorityHealth.com***

You can also complete this form electronically in the Provider Portal (preferred).

SECTION 1 — Priority Health member information

Member name	
Date of birth	
Medicare beneficiary ID or member ID	

SECTION 2 — Attesting provider information

Provider name (attesting clinician)	
Provider relationship to member	☐ Primary Care Provider (PCP) ☐ Treating specialist (type):

	☐ Other:
NPI	
Tax ID (optional)	
Practice/facility	
Phone	
Fax/email (for correspondence)	

SECTION 3 — SSBCI eligibility requirements attestation (All of A, B, C and D must be met to qualify)

CRITERION A: *My patient has one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit overall health or function.*

Check all that apply:

☐ Chronic alcohol use disorder and other substance use disorders ☐ Autoimmune disorder (e.g., polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic lupus erythematosus, psoriatic arthritis, scleroderma) ☐ Cancer ☐ Cardiovascular disorder (e.g., cardiac arrhythmia, coronary artery disease, peripheral vascular disease, valvular heart disease) ☐ Chronic heart failure ☐ Dementia ☐ Diabetic condition (diabetes mellitus or pre-diabetes) ☐ Overweight/obesity/metabolic syndrome ☐ Chronic gastrointestinal disease (e.g., chronic liver disease, NAFLD, hepatitis B, hepatitis C, pancreatitis, IBS, IBD) ☐ Chronic kidney disease (CKD) — not requiring dialysis ☐ CKD requiring dialysis / end-stage renal disease ☐ Severe hematologic disorder (e.g., aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease [excluding trait], chronic venous thromboembolic disorder) ☐ HIV/AIDS ☐ Acute/chronic lung disorder (e.g., asthma, chronic bronchitis, cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension, COPD)	☐ Severe acute respiratory failure ☐ Presence of a tracheostomy ☐ Chronic and disabling mental health condition (e.g., bipolar disorder, major depressive disorder, paranoid disorder, schizophrenia, schizoaffective disorder, PTSD, eating disorder, anxiety disorder) ☐ Neurologic disorder (e.g., ALS, cerebral palsy, epilepsy, extensive paralysis, Huntington disease, multiple sclerosis, Parkinson disease, polyneuropathy, fibromyalgia, chronic fatigue syndrome, spinal cord injury, spinal stenosis with neurologic abnormalities, stroke-related neurologic deficit, traumatic brain injury) ☐ Stroke ☐ Post-organ transplantation care ☐ Condition causing cognitive impairment (e.g., recent hospitalization with delirium, Alzheimer's disease, intellectual/developmental disability, traumatic brain injury, disabling mental illness with cognitive impairment, mild cognitive impairment) ☐ Condition with similar functional challenges requiring similar services (e.g., spinal cord injury, paralysis, limb loss, stroke, arthritis) ☐ Chronic condition that impairs vision, hearing, taste, touch, or smell ☐ Condition requiring continued therapy services to maintain/retain functioning ☐ Chronic hypertension ☐ Osteoporosis ☐ Chronic back pain
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CRITERION B: *My patient has a high risk of hospitalization or other adverse health outcomes.*

Check all that apply (must have happened within the last 12 months):

- ☐ Had one or more inpatient admissions (inclusive of behavioral health) related to chronic condition

- ☐ Had one or more urgent care or ER visits related to the chronic condition
- ☐ History of or at high risk for falls
- ☐ Significant frailty, debility or functional impairment that substantially limits overall health and function

CRITERION C: My patient currently requires intensive care coordination.

Check all that apply (must have happened within the last 12 months):

- ☐ Had two or more outpatient visits related to the chronic condition (including primary care or specialty care visits)
- ☐ Requires home health visits related to chronic conditions
- ☐ Has a need for one or more pieces of durable medical equipment in an outpatient setting limited to Group 3 power/manual wheelchair, noninvasive ventilation (NIV), BiPAP machine, mechanical in-exsufflation device or Group 2 or Group 3 mattress
- ☐ Difficulty with ADLs (bathing, dressing, eating)
- ☐ Mobility limitations

CRITERION D: Functional impact and clinical rationale

Priority Health Medicare plan and SSBCI benefit details:

Plan names	SSBCI items/services
Priority Medicare Align (HMO-POS) Priority Medicare Latitude (HMO-POS)	Healthy food and produce
Priority Medicare D-SNP (HMO) Priority Medicare Dual Premier (HMO D-SNP)	Healthy food and produce, personal care items, household supplies, utilities, pest control, online meal delivery

The requested SSBCI (items/services) have a reasonable expectation of improving or maintaining the health or overall function of my patient. Without this SSBCI, my patient is at risk of (check all that apply):

- ☐ Hospitalization
- ☐ Functional decline
- ☐ Chronic disease exacerbation
- ☐ Increased healthcare utilization

SECTION 4 — Provider attestation

By signing below, I attest that:

- I am the treating clinician (or have direct knowledge of the member's clinical status) and the information provided is accurate, complete, and supported by the medical record.
- I have reviewed and completed Criterion A-D

Printed provider name	Provider signature (electronic signature acceptable)	Date

Provider submission: Digital entry is available on the Provider Portal. Otherwise, fax the completed form to 616.942.0616 or Email **PH-DCC@PriorityHealth.com**. Retain a copy in the member's medical record.