Chronic Condition Verification

You are receiving this notice as your patient has elected to enroll in a Zing Health Chronic Condition Special Needs Plan (C-SNP) for Medicare Advantage.

To complete the enrollment into a C-SNP, Zing Health is required to have the enrollee's current health care provider verify that he or she has been diagnosed with at least one qualifying condition by completing the enclosed Verification of Chronic Condition (VOCC) form. **Your response is required to ensure that your patient remains covered by Zing Health.**

Please complete the enclosed VOCC form based on the box(es) checked below:

- ☐ Complete Sections B and C in the attached VOCC form and return to Zing Health to prevent enrollee loss of coverage.
- ☐ Complete the missing information in Sections B and C (required information was not fully provided originally).
- ☐ **URGENT!** Complete and return attached VOCC form to Zing Health, as the member is pending disenrollment if chronic condition is not confirmed.

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

Phone: 866-946-4458 | **Fax:** 877-289-2295
Email: CSNPVerification@myzinghealth.com

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Provider Name			
Phone		**Fax**	

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Please note that the enrollee has released authorization for Zing Health to obtain this information from you within his or her enrollment application.

Please populate Sections B and C below and send the completed form via (a) fax to 877-289-2295, or (b) encrypted email to CSNPVerification@myzinghealth.com within 48 hours of receipt to ensure uninterrupted coverage for your patient. If this patient is not under your care, 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: Verification of Patient's Chronic Conditions (check all that apply)		
☐ Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolism)	☐ End Stage Renal Disease (any mode of dialysis)	
	☐ Patient does not have any of these chronic conditions	
☐ Chronic heart failure	☐ Patient is not (or no longer) under my care	
☐ Diabetes (Type I or Type II)	☐ Above provider does not (or no longer) works here	
Section C: Provider Information		
Printed Name:	Title:	
Signature:	Date:	
Practice Stamp/Seal:		

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