Verification of Chronic Condition

Diagnoses of Diabetes and/or Osteoarthritis

(IMPORTANT: PLEASE RETURN WITHIN 10 DAYS OF ORIGINAL RECEIPT)

The applicant listed below has applied for a special needs Medicare plan through Humana. This plan will provide the applicant with additional benefits related to his or her condition(s), such as supplemental drug coverage. In order for the applicant to qualify, a physician or physician's office must confirm his or her diagnosis by completing this form. **Your assistance is appreciated.**

Applicant's Name: _____

Applicant's Address:_____

Applicant's Date of Birth:_____

Humana ID: _____
Customer Number: _____
Sub Group#: _____
Proposed Effective Date_____

My signature below authorizes information regarding my chronic condition to be shared with Humana.

_____ _____
Applicant's Signature Date

To Be Completed by the Physician/Physician's Office

I confirm this patient has been diagnosed with the following condition:
Diabetes _____ Osteoarthritis _____ Neither_____
Please check the appropriate box

Confirmation provided by:

_____ _____
Signature Date

_____ _____
Printed Name or Stamp Title

_____ _____
Physician Name Phone

Please return to the following address:
Humana
P.O. Box 14309
Lexington, KY 40512-4309

For questions, please call 1-800-457-4708.

Medicare-approved HMO and PPO Special Needs Plans (SNP) available to anyone who meets the specific eligibility requirements of the SNP and is enrolled in both Part A and Part B of Medicare through age or disability. To qualify for a Chronic Disease SNP, physician diagnosis of the disease must be verified

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