brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

PRE-ENROLLMENT QUALIFICATION ASSESSMENT TOOL FOR CARDIOVASCULAR DISEASE & DIABETES

This form must be submitted with the enrollment application for Embrace Care Drug Savings (HMO C-SNP) Plan 35 & Embrace Choice for Medi-Medi (HMO C-SNP) Plan 36.

First Name:	MI:	Last Name:
Gender: ❑ Male ❑ Female	DOB:	
Address:		
City:	State:	Zip:

Is this a licensed nursing home?: ❑ Yes ❑ No Do you receive SSI or SSDI?: ❑ Yes ❑ No

MEDICARE

Do you have Medicare Part A? ❑ Yes ❑ No ❑ Not Sure
Do you have Medicare Part B? ❑ Yes ❑ No ❑ Not Sure
(If the answer is "No" to either question, the candidate does not qualify.
If not sure, then the candidate's name will be sent for an eligibility check.)

CLINICAL QUALIFYING QUESTIONS

(If any of the following are checked, candidate pre-qualifies)
Have you ever been told by a doctor that you have any of the following illnesses?
(Check all that apply)

❑ Cardiovascular Disease
❑ Heart Failure (of any kind)
❑ Hypertension/High Blood Pressure (Stage A CHF)
❑ Hypertensive Heart with Chronic Kidney Disease
❑ History of stroke
❑ Diabetes
❑ Borderline Diabetes
❑ High Blood Sugar
❑ Hypertensive Heart (of any kind)

MEDICATION QUESTIONS

1. Are you now or have you ever taken medication for an illness listed above? ❑ Yes ❑ No
2. Have you ever been on Insulin injections? ❑ Yes ❑ No
3. Have you ever taken Metformin? ❑ Yes ❑ No
2. What medications are you currently taking? _____

_____

PRIMARY PHYSICIAN: _____

Name of physician and his/her clinic or location/phone number

SPECIALIST: _____

Name of physician and his/her clinic or location/phone number

Candidate Signature:	Date:
Agent Signature:	Agent Printed Name: