Dear Doctor,

Member Name:	**Member DOB:**	**Clever Care Health Plan ID Number:**

is requesting Special Supplemental Benefit(s) for the Chronically Ill (SSBCI) benefit.

To receive this benefit, I must have at least one of the chronic conditions listed below verified by a healthcare provider.
Please check the appropriate box(es) below, complete the form, and fax back to 657-220-8227 ASAP.

Autoimmune disorders	☐ **Cancer** (actively monitoring**)**	**Cardiovascular disorders**	☐ **Chronic alcohol & other drug dependence**
☐ Polyarteritis nodosa ☐ Polymyalgia rheumatica ☐ Polymyositis ☐ Rheumatoid arthritis ☐ Systemic lupus erythematosus	☐ **Dementia** ☐ **Diabetes** ☐ **End-stage liver disease** ☐ **End-stage renal disease (ESRD)** ☐ **HIV/AIDS**	☐ Cardiac arrhythmias ☐ Coronary artery disease ☐ Chronic heart failure ☐ Peripheral vascular disease ☐ Chronic venous thromboembolic disorder	
Chronic and disabling mental health conditions ☐ Bipolar disorders ☐ Major depressive disorders ☐ Paranoid disorder ☐ Schizophrenia ☐ Schizoaffective disorder	**Chronic lung disorders** ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Pulmonary fibrosis ☐ Pulmonary hypertension	**Neurologic disorders** ☐ Amyotrophic lateral sclerosis (ALS) ☐ Epilepsy ☐ Extensive paralysis (hemiplegia, quadriplegia, paraplegia, monoplegia) ☐ Huntington's disease ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Polyneuropathy ☐ Spinal stenosis ☐ Stroke and stroke-related neurologic deficit	**Severe hematologic disorders** ☐ Aplastic anemia ☐ Hemophilia ☐ Immune thrombocytopenic purpura ☐ Myelodysplastic syndrome ☐ Sickle-cell disease (excluding sickle-cell trait) ☐ Chronic venous thromboembolic disorder

Please complete and sign the form and fax back to 657-220-8227, thank you.

Signature: ____

Date: ____