

Please complete and submit this form with your enrollment application. You must have one of the qualifying conditions listed below. In addition, please provide contact information for a physician that Central Health may contact to verify your condition(s). If your eligibility cannot be verified during the first month of enrollment, you will be disenrolled from Central Health Focus Plan HMO C-SNP at the end of the second month.

Applicant Information		
Last Name	First Name	Middle Initial
Medicare ID Number	Date of Birth (MM/DD/YY)	Phone Number
Health Information		
Have you been diagnosed with <b>diabetes</b> (high blood sugar) or are you taking insulin or other medications to control your blood sugar?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with <b>chronic</b> or <b>congestive heart failure (CHF)</b> , have a weak heart, or had fluid retention in the lungs or swollen legs due to a heart problem?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with <b>cardiac arrhythmia</b> or atrial fibrillation (AFib) or have you had problems with rapid, irregular heartbeat?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with <b>coronary artery disease (CAD)</b> or <b>peripheral vascular disease</b> , had a heart attack, or experienced poor circulation due to hardening of the arteries or veins?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with <b>chronic venous thromboembolic disorder</b> or had blood clots in the veins more than once?		<input type="checkbox"/> Yes <input type="checkbox"/> No
List the medications you are taking to treat your condition(s):		
Physician Who Can Verify Your Condition(s)		
Physician Name:	Phone:	Fax:
Office Address:		
_____ Physician Signature		_____ Date
Authorization for Disclosure of Health Information		
I authorize the provider listed above to disclose my health information and/or provide medical records to Central Health Medicare Plan.		
_____ Print Applicant Name	_____ Applicant Signature	_____ Date

For more information or for assistance with this form, please call Member Services at 1-866-314-2427, 7 days a week, 8 AM - 8 PM (TTY users should call 711).