Bright HealthCare

Bright HealthCare Pre-Enrollment Qualification Assessment Tool

IMPORTANT: Complete if Enrolling in the Bright Advantage Harmony Choice Chronic Condition Special Needs Plan

Bright Advantage Harmony Choice Plan is a Special Needs Plan (SNP) for individuals with certain chronic mental health conditions. To enroll in this plan, Medicare requires that Bright HealthCare verify your chronic condition. This is a two-step process:

Step One

Please complete this form and return it to us with your completed enrollment application. If you can answer "yes" to at least one of the chronic condition questions, you may pre-qualify for enrollment in a Bright HealthCare Chronic Condition SNP (C-SNP).

Step Two

Bright HealthCare must verify your chronic condition within one month of your enrollment. Note: If we are unable to verify your chronic condition, we must disenroll you from the C-SNP. That is why it is important to give us contact information for a doctor or clinic that can verify your condition (see page 3 of this form).

Applicant information		
LAST Name:	FIRST Name:	Middle Initial (Optional):
Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Medicare Number: __ __ __ __ – __ __ __ – __ __ __ __	
Phone Number: __ __ __ – __ __ __ – __ __ __ __	Alternate Phone Number (cell): __ __ __ – __ __ __ – __ __ __ __	
☐ By checking this box, you authorize Bright HealthCare and its affiliates to send you text messages with information related to your health plan.		
Email address: _____ ☐ By checking this box, you authorize Bright HealthCare and its affiliates to send you information related to your health plan by email.		

Chronic Condition Questions

Have you ever been told by a doctor that you have any of the following illnesses? Please check all that apply.

- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Paranoid Disorder

Are you now or have you ever taken medication for an illness listed above? ☐ Yes ☐ No

What medications are you currently taking? _____

_____

_____

_____

_____

Health care provider(s) who can verify your chronic condition(s)

Provider #1 (Primary Physician)	Provider #2 (Psychiatrist)
Provider Name:	Provider Name:
Provider Phone Number: __ __ __ – __ __ __ – __ __ __ __	Provider Phone Number: __ __ __ – __ __ __ – __ __ __ __
Provider Fax Number: __ __ __ – __ __ __ – __ __ __ __	Provider Fax Number: __ __ __ – __ __ __ – __ __ __ __
Clinic Location:	Clinic Location:

Authorization for use and disclosure of health information to verify chronic condition(s) for purpose of health plan eligibility

I authorize the providers listed above to disclose my health information to Bright HealthCare to verify that I have been diagnosed with a chronic condition that qualifies me for enrollment in a Bright HealthCare Chronic Condition Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated above.

Note: Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth above, consistent with state and federal law concerning the privacy of such information.

Applicant Name (printed): _____

Applicant/Authorized Representative Signature: _____

Date: _____

To be completed by provider or provider representative

Provider Attestation
For the purpose of confirming eligibility to enroll in a Chronic Condition Special Needs Plan, I hereby attest that the Applicant identified above has the following health condition(s):

- Major Depressive Disorder ☐ Yes ☐ No
- Bipolar Disorder ☐ Yes ☐ No
- Schizophrenia ☐ Yes ☐ No
- Schizoaffective Disorder ☐ Yes ☐ No
- Paranoid Disorder ☐ Yes ☐ No

Provider Name (printed): _____

Provider or Provider Representative Signature: _____

Today's Date: _____

Please return this form to Bright HealthCare within three (3) business days of receipt

By Fax:
1-877-346-0321
ATTN: Bright HealthCare Medicare Advantage – Enrollment

By Mail:
Bright HealthCare Medicare Advantage – Enrollment
P.O. Box 1731
Portland, ME 04104

If you have any questions about this form, please call: **1-844-926-4522**, 8 a.m. to 8 p.m. local time, 7 days a week, Oct. 1 - March 31; 8 a.m. to 8 p.m. local time, Monday - Friday, April 1 - Sept. 30, excluding Federal holidays.