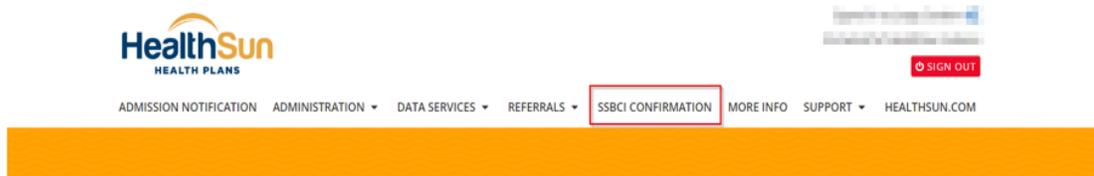


# Special Supplemental Benefits for the Chronically Ill (SSBCI) Provider Confirmation

## Specialist:

1. After login click the *SSBCI Confirmation* tab.



2. Search and Select the Provider Name that you Represent for this Attestation, you can search by Name or Provider ID number with the plan.

Search and Select the Provider Name that you Represent for this Attestation

If you need to search for a member not already displayed below, please fill in the 3 fields below and click the Search Members button:

3. After provider is selected, enter member information, all three fields are required for search.

Search and Select the Provider Name that you Represent for this Attestation

Provider Number: [redacted] Par

Address: 6705-450 St. Alameda, CA 94608

If you need to search for a member not already displayed below, please fill in the 3 fields below and click the Search Members button:

<p>Member Number:</p> <input type="text" value="E.g. H5000000"/>	<p>Member Last Name:</p> <input type="text" value="Member's Last Name"/>	<p>Member DOB:</p> <input type="text" value="Member's Date of Birth"/>
<p>SEARCH MEMBERS</p>		

If you need to search for a member not already displayed below, please fill in the 3 fields below and click the Search Members button:

Member Number:

Member Last Name:

Member DOB:

- Once member information populates, click dropdown for "Meets SSBCI criteria?" to select if member meets or does not meet criteria.

Member Number	First Name	Last Name	DOB	PCP ID	PCP	Member Effective Date	Meets SSBCI Criteria?
<input type="text"/>	<input type="text"/>						

Agreement

By typing in the physician's name below you certify that the above reference patient(s) is under the above referenced provider's care, and the above selection(s) is correct.

Attesting Physician Name:

- After selection has been made, enter attesting physician's name as a signature and click "Submit".

Member Number	First Name	Last Name	DOB	PCP ID	PCP	Member Effective Date	Meets SSBCI Criteria?
<input type="text"/>	<input type="text"/>						

Agreement

By typing in the physician's name below you certify that the above reference patient(s) is under the above referenced provider's care, and the above selection(s) is correct.

Attesting Physician Name:

## Viewing Submission

1. To view the submission, use the *Referrals* tab and select “All Referrals”.



2. Select the date of the submission by clicking the calendar image, choose date and click “Search Referrals” to view results.

The screenshot shows a search filter interface. On the left, there is a "Date From:" field with a calendar icon. A calendar for "October 2024" is displayed, with the date "17" highlighted in a red box. To the right of the calendar is a "Date To:" field with a calendar icon. Below these fields is a "By Status:" dropdown menu with a checked box and the text "E.g. New, Pending, Approved". A blue "SEARCH REFERRALS" button is located at the bottom right of the filter area.

3. When results load, click the green pencil icon to view submission.

NUMBER OF RESULTS: 1

First Previous 1 Next Last

Referral Number	Type	Member	Specialist	PCP #	Date Created	Status	Last Modified by	Last Modified	
	SSBCI ELIGIBILITY				10/17/2024	New Referral	Jorge.Catalan	10/17/2024	

4. You will view the submission information including a PDF version of the signed attestation.

MEMBER INFORMATION		REFERRAL INFORMATION	
Member ID: [REDACTED]	Member: [REDACTED]	Discontinued/Cancelled Treatment: <input type="checkbox"/> No	
Phone: [REDACTED]	Date of birth: [REDACTED]	Status: <input type="button" value="New Referral"/>	Expedited: <input type="checkbox"/> No
		Specialist: [REDACTED]	Specialist ID: [REDACTED]
		Date of Service: <input type="text" value="01/01/2025"/>	<input type="button" value="UPDATE"/>
<b>MEMBER'S PCP</b>		Specialist Address: [REDACTED]	
PCP: [REDACTED]		Phone: [REDACTED]	
Phone: [REDACTED]		Fax: [REDACTED]	
Referral Valid: [REDACTED]		Email: [REDACTED]	
		Facility: [REDACTED]	

### Diagnosis Codes

Code	Description
R69	Illness, unspecified

### CPT Codes

Code	Description	Visits Approved
SSBCI	Supplemental Benefits for Chronically Ill	8

### Files

File Name
SSBCI Form_H5764168_20241017120059.pdf

## Provider Confirmation Form Special Supplemental Benefits for the Chronically Ill (SSBCI)

This form is used to make sure the member meets eligibility requirements for Special Supplemental Benefits for the Chronically Ill (SSBCI) as required by CMS. Full eligibility requirements can be found on the next page.

The member listed below has requested access to one or more Special Supplemental Benefits for the Chronically Ill, which by CMS guidelines, requires them to have a qualifying chronic condition and meet specific clinical requirements as outlined on the following pages.

### Member Information

**Member First and Last Name:** [REDACTED]  
**Date of Birth:** [REDACTED]  
**Medicare Beneficiary ID:** [REDACTED]  
**Member ID:** [REDACTED]

By typing in your name below representing your electronic signature, you certify that the above referenced patient is under the below referenced provider's care and:

- Meets the Defined Criteria  
 Does Not Meet the Defined Criteria

### Provider Information

**Provider First and Last Name:** [REDACTED]  
**Address:** [REDACTED]  
**Phone Number:** [REDACTED]  
**Fax Number:** [REDACTED]  
**NPI:** [REDACTED]  
**Electronic Signature:** Jorge C

**Date:** 10/17/2024