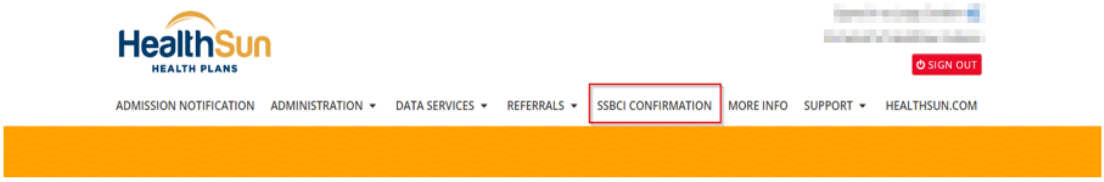
Special Supplemental Benefits for the Chronically Ill (SSBCI) Provider Confirmation

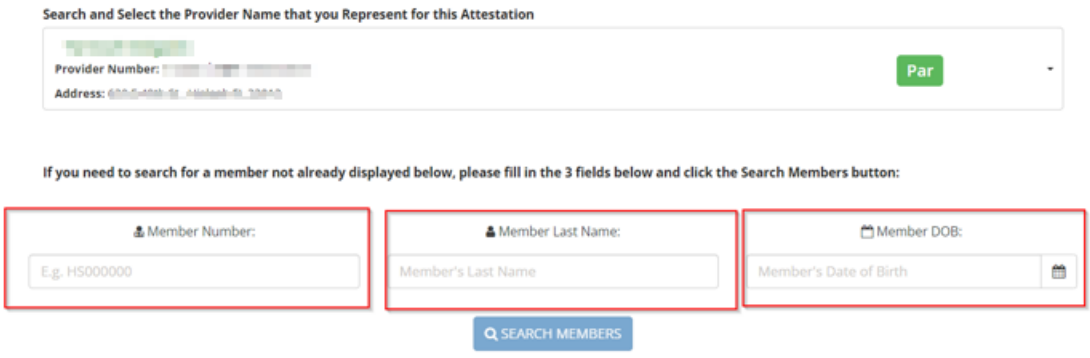
Specialist:

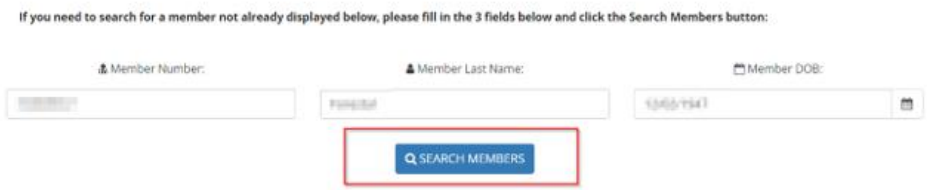
1. After login click the *SSCBI Confirmation* tab.



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.

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



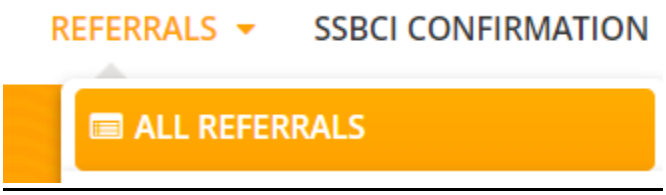


4. Once member information populates, click dropdown for "*Meets SSBCI criteria?*" to select if member meets or does not meet criteria.

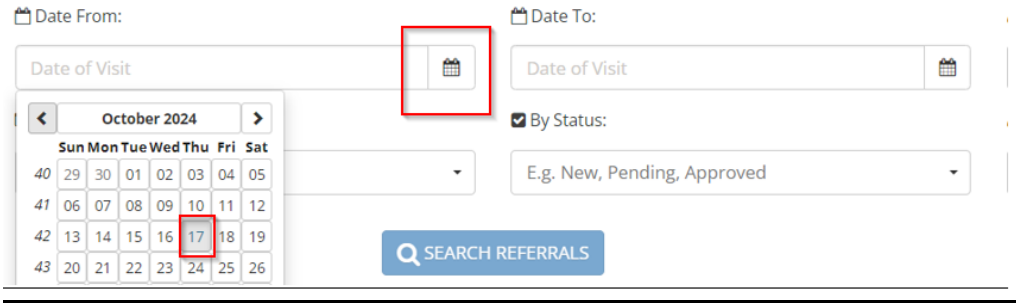
5. After selection has been made, enter attesting physician's name as a signature and click "Submit".

Viewing Submission

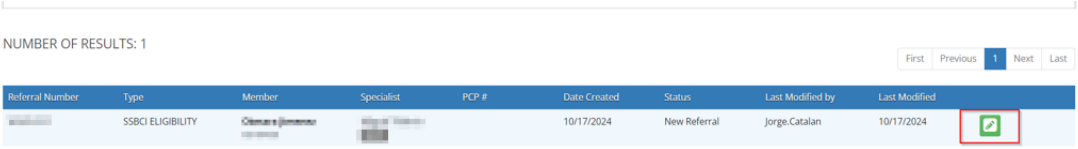
1. To view the submission, use the *Referrals* tab and select “All Referrals”.



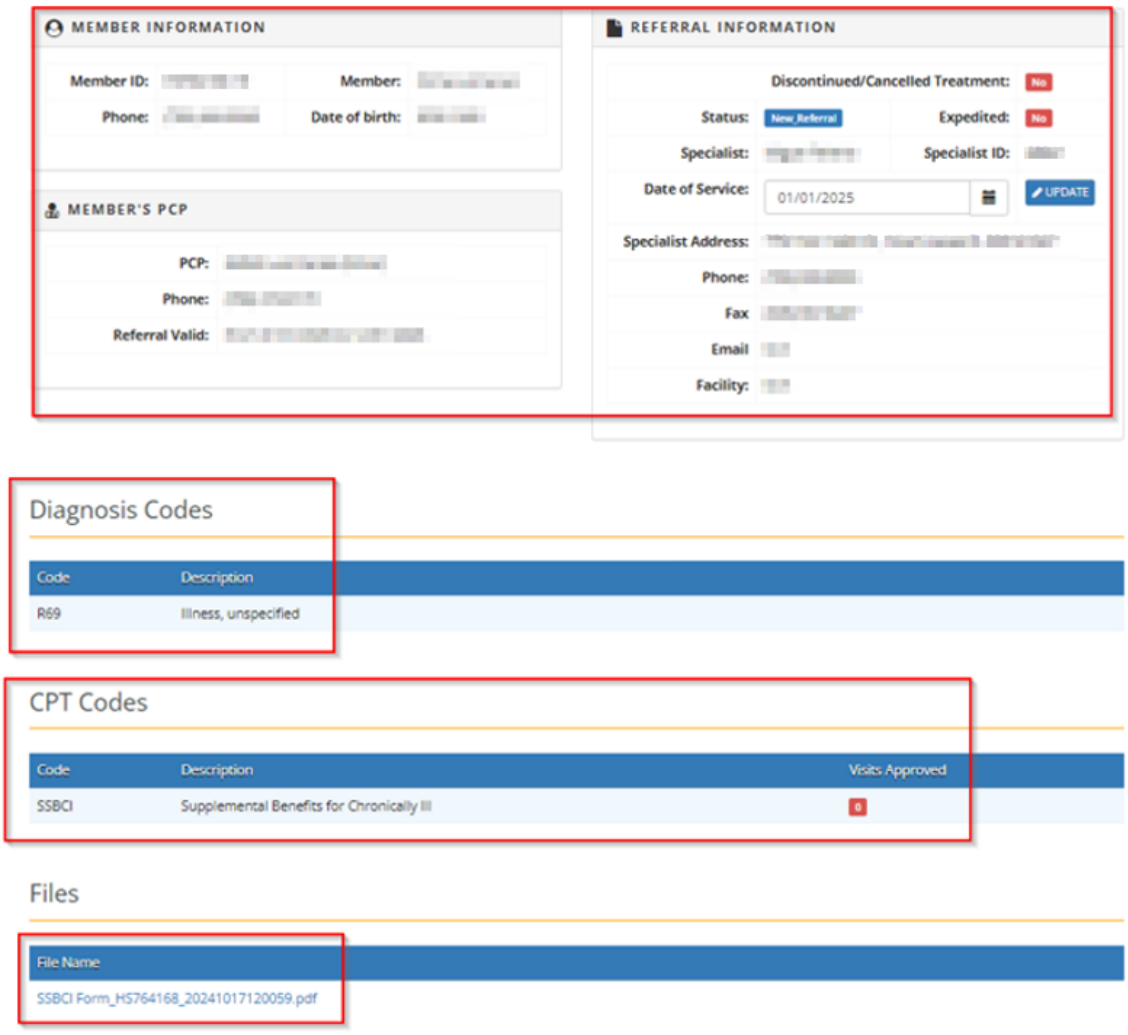
2. Select the date of the submission by clicking the calendar image, choose date and click “Search Referrals” to view results.



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



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



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:
Date of Birth:
Medicare Beneficiary ID:
Member ID:

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:
Address:
Phone Number:
Fax Number:
NPI:
Electronic Signature: Jorge C **Date:** 10/17/2024