



Chronic Condition Verification

You are receiving this notice because your patient has enrolled in a Zing Health Medicare Advantage Chronic Condition Special Needs Plan (C-SNP). To complete enrollment, Zing Health is required to obtain verification of the diagnosis of a qualifying condition from the member's current healthcare provider.

Please note that:

- Your patient has authorized Zing to obtain this data from you within their enrollment application.
- Your patient is at risk of **disenrollment** if not verified within 60 days of their plan effective date.
- This form can be completed by the enrollee's provider or their office staff.

Instructions: Please complete Sections B and C and return the form within 48 hours via fax (877-289-2295) or encrypted email (CSNPVerification@myzinghealth.com) to avoid a lapse in your patient's coverage. If the patient is not under your care, please check the appropriate box in Section B so we can update our records.

Phone: 866-946-4458 | **Fax:** 877-289-2295
Email: CSNPVerification@myzinghealth.com

Confidentiality Notice: The information contained in this facsimile may be confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action is regards to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this coversheet along with its contents, and delete it from your system, if applicable.

This attestation can be obtained verbally on a recorded phone line, via **encrypted** email, or via faxed attestation form. You or your office staff may complete this verification.

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Provider Name			
Phone		Fax	

Your patient has enrolled in a Zing Health Medicare Advantage Chronic Condition Special Needs Plan (C-SNP). To complete enrollment, Zing Health is required to obtain verification of the diagnosis of one or more of the qualifying conditions listed in Section B of the form below from the member's current healthcare provider.

Please note that:

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- Your patient is at risk of **disenrollment** if not verified within 60 days of their plan effective date.
- This form can be completed by the enrollee's provider or their office staff.

Instructions: Please complete Sections B and C and return the form within 48 hours via fax (877-289-2295) or encrypted email (CSNPVerification@myzinghealth.com) to avoid a lapse in your patient's coverage. If the patient is not under your care, please check the appropriate box in Section B so we can update our records.

Section A: Patient Information		
First Name:	Last Name:	MI:
Medicare ID:	Date of Birth:	
Section B: Verification of Patient's Chronic Conditions (<i>check all that apply</i>)		
☐ Cardiovascular Disorders (<i>limited to Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, and/or Valvular Heart Disease</i>)	☐ Metabolic Syndrome	
☐ Chronic Heart Failure	☐ Overweight (<i>BMI 25 - 29.9</i>), or Obesity (<i>BMI ≥ 30</i>)	
☐ Chronic Kidney Disease (<i>Stages 1-5 including ESRD</i>)	Non-Qualifying Options ☐ Above provider does not (or no longer) work here ☐ Patient does not have any of these conditions ☐ Patient is not (or no longer) under my care	
☐ Diabetes (<i>Type I or II</i>)		
Section C: Signer Information		
Printed Name:	Title:	
Signature:	Date:	
Practice Stamp/Seal:		