MASS ADVANTAGE

Provider Attestation of SSBCI Eligibility

Members with certain chronic health conditions may be eligible for additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI).

Mass Advantage must receive information showing that your patient has at least one of the listed chronic conditions and meets all of the following criteria:

- Is life threatening or significantly limits the patient's overall health or function
- At a high-risk of hospitalization or other adverse health outcomes
- Requires intensive care coordination

To help determine if your patient is eligible for SSBCI, we'll need some information from you. Please complete this form and return it to Mass Advantage, attn Member Experience Team:

Fax	816-502-4585
Email	memberservices@massadvantage.com
Mail	PO Box 219975 Kansas City, MO 64121-9975

All attestations will be reviewed and processed within 5-7 business days upon receipt.

If you have any questions, please contact our Provider Services team at:

HMO Members: (844) 918-0114, TTY: 711

PPO Members: (844) 915-0234, TTY: 711

Calls to these numbers are free. From October 1 to March 31, we're available 7 days a week from 8 am to 8 pm EST. From April 1 to September 30, we're available Monday through Friday from 8 am to 8 pm EST. A messaging system is used after hours, weekends and on federal holidays.

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Patient Information:

First Name: _____ Last Name: _____

Mass Advantage Member ID: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Provider Attestation:

Please select all of the qualifying conditions that apply to your patient. To be eligible for SSBCI benefits, the patient must have one or more of the conditions listed below.

- ☐Autoimmune disorders
- ☐Cancer
- ☐Cardiovascular disorders
- ☐Chronic alcohol and other drug dependence
- ☐Chronic and disabling mental health conditions
- ☐Chronic heart failure
- ☐Chronic lung disorders
- ☐Dementia
- ☐Diabetes
- ☐End-stage liver disease
- ☐End-stage renal disease (ESRD)
- ☐HIV/AIDS
- ☐Neurologic disorders
- ☐Severe hematologic disorders
- ☐Stroke

I confirm that the information provided above is accurate and documented in the patient's medical record.

Provider Name: _____ Provider NPI: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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