Attestation for Independence and Safe Mobility with AAA Special Supplemental Benefit for the Chronically Ill (SSBCI)

This plan includes a Special Supplemental Benefit for the Chronically Ill (SSBCI) called "Independence and Safe Mobility with AAA". To be eligible for this benefit, you must have one or more of the following chronic conditions:

Cancer	Excluding pre-cancer conditions or in-situ status
Cardiovascular disorders	Limited to: • Cardiac arrhythmias (also known as Abnormal Heart Rhythm) • Coronary artery disease (also known as history of chest pains, heart attacks, or hardening of the arteries of the heart) • Peripheral vascular disease (also known as hardening of the arteries of the legs) • Chronic venous thromboembolic disorder (also known as blood clots in the legs)
Chronic heart failure	
Diabetes mellitus	(Also known as Diabetes Type I or Type II)
Chronic lung disorders	Limited to: • Asthma • Chronic bronchitis (also known as Chronic Obstructive Pulmonary Disease or COPD) • Emphysema (also known as Chronic Obstructive Pulmonary Disease or COPD) • Pulmonary fibrosis (also known as scarring of lung tissue) • Pulmonary hypertension (also known as high blood pressure in the lungs)
Stroke	

Please submit this page only of the completed SSBCI form to:

Fax: (877) 251-3600
Mail to: Blue Shield of California, P.O. Box 948, Woodland Hills, CA 91365-9856
Email to: WHMembership@blueshieldca.com

If you have questions about completing the form, please contact Customer Care by calling (800) 776-4466 (TTY: 711), 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m. Saturday and Sunday) from April 1 through September 30 or visit blueshieldca.com/medicare

Member/Applicant First Name: _____

Member/Applicant Last Name: _____

Medicare ID: _____ Member/Applicant Date of Birth: _____

Member/Applicant Email: _____

Member/Applicant Phone Number: _____

Member Attestation for Eligibility

☐ I acknowledge that I meet one or more of the chronic conditions stated above to qualify for the "Independence and Safe Mobility with AAA" Special Supplemental Benefit for the Chronically Ill. My plan may contact my provider (listed below) if they need more information. I give permission to the plan or one of its agents to contact me regarding my benefit. I also understand unused benefits do not roll over to the next calendar year. I understand that the "Independence and Safe Mobility with AAA" SSBCI is only available to me during my active eligibility with a Blue Shield Medicare Advantage plan that offers this benefit.

Member Signature: _____ Date: _____

OR

Power of Attorney Name: _____

Power of Attorney Phone Number: _____ Relationship to Enrollee: _____

Power of Attorney Address: _____

Power of Attorney Signature: _____ Date: _____

Provider Acknowledgment

☐ I acknowledge that the member/applicant referenced above meets one or more of the eligibility requirements stated above to qualify for the "Independence and Safe Mobility with AAA" Special Supplemental Benefit for the Chronically Ill.

Provider Name: _____ Provider Phone Number: _____

Provider Signature: _____ Date: _____

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad. Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻 狀況、性別認同、性取向、年齡或殘障為由而進行歧視。