



Special Supplemental Benefits for the Chronically Ill (SSBCI)

Pre-Qualification Assessment Form

This form must be completed to qualify for SSBCI under any Solis plan. Please submit with enrollment form via: fax (305-675-0933) or email (sales@solishealthplans.com).

Special Supplemental Benefits for the Chronically Ill (SSBCI) are only available to members who have specific health conditions and are at risk of certain adverse health outcomes. **You are not automatically enrolled in these benefits.**

To determine your eligibility for SSBCI benefits, we review available health information, which may include your claims history, Health Risk Assessment (HRA), medical records, and information from your doctor or other health care providers. If needed, we may contact your Primary Care Provider (PCP) to confirm your eligibility.

Do you have any of the following qualifying conditions? Please check all that apply.	
☐ Yes ☐ No	Autoimmune disorders limited to: - Polyarteritis nodosa - Polymyalgia rheumatica - Polymyositis - Rheumatoid arthritis - Systemic lupus erythematosus - Scleroderma - Psoriatic Arthritis - Dermatomyositis
☐ Yes ☐ No	Cancer, excluding pre-cancer conditions or in-situ (localized) status
☐ Yes ☐ No	Cardiovascular disorders limited to: - Cardiac arrhythmias - Coronary artery disease - Peripheral vascular disease - Chronic venous thromboembolic disorder - Valvular heart disease
☐ Yes ☐ No	Chronic heart failure
☐ Yes ☐ No	Diabetes mellitus
☐ Yes ☐ No	Overweight, obesity, and metabolic syndrome.
☐ Yes ☐ No	Chronic gastrointestinal diseases limited to: - Chronic liver disease - Non-alcoholic fatty liver disease (NAFLD) - Hepatitis B - Hepatitis C - Pancreatitis - Irritable bowel syndrome - Inflammatory bowel disease
☐ Yes ☐ No	Chronic kidney diseases (CKD) limited to: - CKD requiring dialysis/End-stage renal disease (ESRD) - CKD not requiring dialysis
☐ Yes ☐ No	Severe hematologic disorders limited to: - Aplastic anemia - Hemophilia - Immune thrombocytopenic purpura - Myelodysplastic syndrome - Sickle-cell disease (excluding sickle-cell trait) - Chronic venous thromboembolic disorder

☐ Yes ☐ No	Chronic lung disorders limited to: • Asthma, Chronic bronchitis • Cystic Fibrosis • Emphysema • Pulmonary fibrosis • Pulmonary hypertension • Chronic Obstructive Pulmonary Disease (COPD)
☐ Yes ☐ No	Neurologic disorders limited to: • Amyotrophic lateral sclerosis (ALS) • Epilepsy • Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia) • Huntington's disease • Multiple sclerosis • Parkinson's disease • Polyneuropathy • Fibromyalgia • Chronic fatigue syndrome • Spinal cord injuries • Spinal stenosis • Stroke-related neurologic deficit
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Post-organ transplantation care
☐ Yes ☐ No	Immunodeficiency and Immunosuppressive disorders
☐ Yes ☐ No	Conditions associated with cognitive impairment limited to: • Alzheimer's disease • Intellectual disabilities and developmental disabilities • Traumatic brain injuries • Disabling mental illness associated with cognitive impairment • Mild cognitive impairment
☐ Yes ☐ No	Conditions with functional challenges and require similar services including the following: • Spinal cord injuries • Paralysis • Limb loss • Stroke • Arthritis
☐ Yes ☐ No	Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
☐ Yes ☐ No	Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
☐ Yes ☐ No	Chronic hypertension
If any of the below are marked as Yes, you will need to submit a HIPAA Privacy Authorization Form with this document.	
☐ Yes ☐ No	Chronic alcohol and other drug dependence
☐ Yes ☐ No	Chronic and disabling mental health conditions limited to: • Bipolar disorders • Major depressive disorder • Paranoid disorder • Schizophrenia • Schizoaffective disorder
☐ Yes ☐ No	Chronic and disabling mental health conditions limited to: • Post-traumatic stress disorder (PTSD) • Eating disorders • Anxiety disorders
☐ Yes ☐ No	Dementia
☐ Yes ☐ No	HIV/AIDS

Beneficiary Information

Beneficiary Name:

MBI Number:

Date of Birth:

For Provider use only: Review & Sign☐

I confirm my records for this patient include a diagnosis of one or more of the above qualifying conditions and the patient is at high risk of hospitalization or other adverse health outcomes.

☐

No, my records for this patient do not include a diagnosis of one or more of the above qualifying conditions, is at high risk of hospitalization or other adverse health outcomes.

☐

My records indicate this is **not** my patient.

I hereby attest that the information selected above is correct and noted in the patient's medical record.

Provider's Name (Print):

Credentials: (MD, DO, APRN, PA)

NPI:

Telephone:

Provider's Signature:

Date: