blue california

Attestation for Healthy Grocery Special Supplemental Benefit for the Chronically Ill (SSBCI) - Blue Shield Inspire (HMO D-SNP)

This plan includes a Special Supplemental Benefit for the Chronically Ill (SSBCI) called "Healthy Grocery". To be eligible for this benefit, you must have one or more of the following chronic conditions. Please select from the qualifying conditions below:

☐	**End Stage Renal Disease (ESRD) requiring dialysis**	(Also known as End Stage Kidney Disease requiring dialysis)
☐	**Diabetes mellitus**	(Also known as Diabetes Type I or Type II)
☐	**Chronic Heart Failure**	

Please submit **both** pages of the completed Blue Shield Inspire 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, year round, 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 "Healthy Grocery" 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 from month to month. I understand that the "Healthy Grocery" 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 "Healthy Grocery" Special Supplemental Benefit for the Chronically Ill.

Provider Name: _____ Provider Phone Number: _____

Provider Signature: _____ Date: _____