



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

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:

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- 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)

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- Diabetes mellitus** (Also known as Diabetes Type I or Type II)

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- Autoimmune Disorders**
- Limited to:
- Polyarteritis nodosa
 - Polymyalgia rheumatica
 - Polymyositis
 - Rheumatoid arthritis
 - Systemic lupus erythematosus
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Please submit **both** pages of the completed Blue Shield Balance 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 **(888) 802-4423** (TTY: 711), 8 a.m. to 8 p.m., seven days a week, 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: _____

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律, 並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。