



IMPERIAL HEALTH PLAN
OF CALIFORNIA

C-SNP Pre-Enrollment Qualification Assessment Tool (PQAT)

IMPORTANT – PLAN SELECTION REQUIRED

Imperial Health Plan of California, Inc. (HMO) (HMO SNP) offers two distinct C-SNP plans under Medicare Contract H5496. The qualifying chronic conditions differ. Please select the plan the beneficiary is applying for and complete ONLY the corresponding sections.

☐ **Imperial Senior Value (HMO C-SNP) – PBP 005** → Diabetes Mellitus, Chronic Heart Failure, AND/OR Cardiovascular Disorders

☐ **Imperial Flex (HMO C-SNP) – PBP 017** → Diabetes Mellitus AND/OR Cardiovascular Disorders (CHF is NOT a qualifying condition for this plan)

Please complete this form and return it to us with your enrollment application. Imperial will validate your chronic condition with your doctor within 30 days of the effective enrollment date. If we are unable to verify your chronic condition, we need to disenroll you from this plan.

BENEFICIARY INFORMATION

Last Name	First Name	Middle Initial
Date of Birth (MM/DD/YYYY)	Medicare Beneficiary Identifier (MBI)	Phone Number

Date and Time Assessment Completed (if face-to-face): _____
OR Receipt Date (if mail or electronic): _____

DIABETES MELLITUS (Applies to BOTH Plan 005 and Plan 017)

Complete this section if the beneficiary has or may have Diabetes Mellitus.

Have you been diagnosed by a doctor or other licensed healthcare professional with Diabetes Mellitus (Type 1 or Type 2)?

☐ **YES** ☐ **NO**

Have you experienced increased thirst, frequent urination, extreme hunger, unexplained weight loss, slow-healing sores, or frequent infections?

☐ **YES** ☐ **NO**

Have you had problems with high blood sugar (hyperglycemia)?

☐ **YES** ☐ **NO**

Do you currently take medications (insulin, oral agents, or non-insulin injectables) and/or follow a special diet to control your blood sugar?

☐ **YES** ☐ **NO**

CHRONIC HEART FAILURE (Applies ONLY to Plan 005 – Senior Value)

⚠ DO NOT complete this section if the beneficiary is applying for Imperial Flex (PBP 017). Chronic Heart Failure is not a qualifying condition for Plan 017.

Have you been diagnosed by a doctor or other licensed healthcare professional with chronic or congestive heart failure?

☐ YES ☐ NO

Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem?

☐ YES ☐ NO

Do you take medications to prevent leg or hand swelling related to heart failure?

☐ YES ☐ NO

Do you feel fatigue when walking or doing physical activity, or need to stop and rest when walking?

☐ YES ☐ NO

CARDIOVASCULAR DISORDERS (Applies to BOTH Plan 005 and Plan 017)

Complete this section if the beneficiary has or may have a qualifying cardiovascular disorder (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, or valvular heart disease).

Have you ever been diagnosed by a doctor or licensed healthcare professional with a cardiovascular condition such as cardiac arrhythmia, coronary artery disease (including angina), peripheral vascular disease, or valvular heart disease?

☐ YES ☐ NO

Do you experience palpitations, chest pain or tightness, or shortness of breath—particularly during physical activity or at rest?

☐ YES ☐ NO

Have you ever had a stroke, heart attack (myocardial infarction), or been advised that you have elevated cholesterol levels requiring treatment?

☐ YES ☐ NO

Are you currently taking medications for heart rhythm, cholesterol, blood thinners, blood pressure related to heart disease, or to improve circulation?

☐ YES ☐ NO

HEALTH CARE PROVIDER(S) WHO CAN VERIFY THE CONDITION(S)

Physician / Provider Name	Specialty	City
Phone Number	Fax Number	Hospital Affiliation (if any)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the provider(s) listed above to disclose my protected health information to Imperial Health Plan of California to verify that I have been diagnosed with a chronic condition that qualifies me for enrollment in the selected C-SNP plan. This authorization applies to health information concerning my medical history for the chronic condition(s) indicated above.

Beneficiary Signature: _____ Date: _____

PROVIDER ATTESTATION (Required for PQAT Verification)

I hereby attest that my patient listed above has one or more of the following conditions (check only those that apply and that are allowed for the selected plan):

Note: The signing provider must be a physician (as defined in section 1861(r)(1) of the Social Security Act), a physician assistant who meets the qualifications in 42 CFR § 410.74(c), or a nurse practitioner who meets the qualifications in 42 CFR § 410.75(b)(1)(i) and (ii) and must be the enrollee's current treating provider (primary care or specialist for the qualifying condition).

For Plan 005 (Senior Value) AND Plan 017 (Flex):

☐ Diabetes Mellitus

☐ Cardiovascular Disorders (cardiac arrhythmias, CAD, PVD, and/or valvular heart disease)

For Plan 005 (Senior Value) ONLY – Do NOT check for Plan 017:

☐ Chronic Heart Failure

Provider Name (Print)	Provider Signature
Today's Date	Provider Address / NPI (optional)

If you have any questions, please contact our Member Services Department at 1-800-838-8271, TTY: 711. October 1 – March 31: Monday–Sunday 8:00 am–8:00 pm PST April 1 – September 30: Monday–Friday 8:00 am–8:00 pm PST (except holidays). Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal. Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Imperial does not exclude anyone or treat them unfairly because of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-838-8271 (TTY: 711) or speak to your provider.