Attestation for Food and Produce Special Supplemental Benefit for the Chronically Ill (SSBCI) – Blue Shield Medicare + Medi-Cal Plan (HMO D-SNP)

This plan includes a Special Supplemental Benefit for the Chronically Ill (SSBCI) called Food and Produce benefit. To be eligible for this benefit (not all members will qualify), a member must have at least one or more of the following chronic conditions:

- Chronic alcohol use disorder and other substance use disorders (SUDs)
- Autoimmune disorders (polyarteritis nodosa, polymyalgia rheumatica, polymyositis, dermatomyositis, rheumatoid arthritis, systemic lupus erythematosus, psoriatic arthritis, scleroderma)
- Cancer
- Cardiovascular disorders (cardiac arrhythmias, coronary artery disease, peripheral vascular disease, valvular heart disease)
- Chronic heart failure
- Dementia
- Diabetes mellitus
- Overweight, obesity, and metabolic syndrome
- Chronic gastrointestinal disease (chronic liver disease, non-alcoholic fatty liver disease [NAFLD], hepatitis B, hepatitis C, pancreatitis, irritable bowel syndrome, inflammatory bowel disease)
- Chronic kidney disease (CKD): requiring dialysis / end-stage renal disease (ESRD) or CKD not requiring dialysis
- Severe hematologic disorders (aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle-cell disease [excluding sickle-cell trait], chronic venous thromboembolic disorder)
- HIV/AIDS
- Chronic lung disorders (asthma, chronic bronchitis, cystic fibrosis, emphysema, pulmonary fibrosis, pulmonary hypertension, chronic obstructive pulmonary disease [COPD])
- Chronic and disabling mental health conditions (bipolar disorders, major depressive disorders, paranoid disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder, eating disorders, anxiety disorders)
- Neurologic disorders (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)
- Stroke
- Post-organ transplantation care
- Immunodeficiency and immunodepressive disorders
- Conditions associated with cognitive impairment (Alzheimer's disease, intellectual disabilities and developmental disabilities, traumatic brain injuries, disabling mental illness associated with cognitive impairment, mild cognitive impairment)
- Conditions associated with functional challenges and require similar services including the following: spinal cord injuries, paralysis, limb loss, stroke, arthritis
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning

Please submit **both** pages of this completed Blue Shield Medicare + Medi-Cal Plan SSBCI form to:

Fax to: **(877) 251-3660**
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 Service by calling **(800) 452-4413 (TTY: 711),** 8 a.m. to 8 p.m. PT, seven days a week, or visit **blueshieldca.com/medicare**.

Member first name: _____

Member last name: _____

Medicare ID: _____ Member date of birth: _____

Member email: _____

Member phone number: _____

Provider acknowledgment

I understand that the above member must have a certain long-term illness known as a chronic condition to use this benefit.

I acknowledge that the member referenced above:

- ☐ DOES meet the eligibility requirements stated above to qualify for the Special Supplemental Benefit for the Chronically Ill.
  Please add chronic condition _____
- ☐ DOES NOT meet the eligibility requirements stated above to qualify for Special Supplemental Benefit for the Chronically Ill. I recommend the member schedule an office visit.

Provider name: _____ Provider phone number: _____

Provider signature: _____ Date: _____