brand new day Health Maintenance Organization Special Needs Plan	**Pre- Enrollment Qualification Assessment Tool for Diabetes**

Name: ____

first *middle* *last*

Gender: ☐ Male ☐ Female Date of birth: ___________

Address: ____

City: ____ State: ______Zip:_________

Is this a licensed nursing home: ☐ yes ☐ no

Do you receive SSI or SDI: ☐ yes ☐ no

Medicare

Do you have Medicare Part A? ☐ yes ☐ no ☐ not sure

Do you have Medicare Part B? ☐ yes ☐ no ☐ not sure

(If the answer is "No" to either question, the beneficiary does not qualify. If not sure, then the candidate's name will be sent for an eligibility check.)

Clinical Qualifying Questions

(If any of the following are checked, candidate pre-qualifies)

Have you ever been told by a doctor that you have any of the following illnesses? *(Check all that apply)*

- ☐ Diabetes
- ☐ High Blood Sugar
- ☐ Borderline Diabetes

Medication Questions

1. Are you now or have you ever taken medication for an illness listed above?
2. Have you ever been on Insulin injections?
3. Have you ever take Metformin?
4. What medications are you currently taking? ________________________________

   ____

Primary physician:

____

Name of physician and his/her clinic or location / phone number

Specialist:

____

Name of specialist and his/her clinic or location / phone number

___________________ __________ ___________________ ___________________

Candidate Signature *Date* *Agent Signature* *Agent Printed Name*

H0838-PQAT-Diabetes-20130918