Provider Attestation for Supplemental Benefits



Martin's Point Generations Advantage members may be eligible to receive supplemental benefits if they have a specific diagnosis. In instances where Martin's Point Health Care does not have evidence of a specific diagnosis through claims, the member must request this form be filled out by their provider. Once the Plan receives a completed form indicating the presence of one or more the diagnoses listed below, the member will be eligible for certain supplemental benefits on the date we receive the form. Please allow seven (7) business days for processing once the document is received by the plan.

To be filled out by the Generations Advantage plan member:

Generations Advantage Member ID Number: To be filled out by the provider: Please indicate which condition(s) the member has and date diagnosed for each: Chronic Kidney Disease Diabetes Diabetes Date diagnosed: Prediabetes Date diagnosed: History of Falls/or Hip Fracture Date diagnosed: Opioid-Use Disorder Date diagnosed: Date diagnosed: Image: Date diagnosed: Date diagnosed: Date diagnosed: Image: Diabetes Date diagnosed: Image: Date diagnosed: Image: Date diagnosed: Image: Date diagnosed: Date diagnosed: Image: Date diagnosed: Date diagnosed: Date diagnosed: Image: Date diagnosed: Date diagnosed:	Α	Member Information (please print)		
To be filled out by the provider: B Please indicate which condition(s) the member has and date diagnosed for each: Chronic Kidney Disease Date diagnosed:/_/ Diabetes Date diagnosed:/_/ Prediabetes Date diagnosed:/_/ History of Falls/or Hip Fracture Date diagnosed:/_/ Opioid-Use Disorder Date diagnosed:/_/ Chronic Pain (Limited to the following ICD-10 codes): G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 G Date(s) diagnosed:		Member Name:	Date of Birth:/	-
 Please indicate which condition(s) the member has and date diagnosed for each: Chronic Kidney Disease Date diagnosed:// Diabetes Date diagnosed:// Prediabetes Date diagnosed:// History of Falls/or Hip Fracture Date diagnosed:// Opioid-Use Disorder Date diagnosed:// Chronic Pain (<i>Limited to the following ICD-10 codes):</i> G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 G Date(s) diagnosed: Provider National Provider Identifier (NPI):		Generations Advantage Member ID	Number:	
Chronic Kidney Disease Date diagnosed:// Diabetes Date diagnosed:// Prediabetes Date diagnosed:// History of Falls/or Hip Fracture Date diagnosed:// Opioid-Use Disorder Date diagnosed:// Chronic Pain (<i>Limited to the following ICD-10 codes</i>): G89.0 G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 G89.3 C Provider National Provider Identifier (NPI):	To k	e filled out by <u>the provide</u>	<u>er</u> :	
Diabetes Date diagnosed: /_/ Prediabetes Date diagnosed: / History of Falls/or Hip Fracture Date diagnosed: / Opioid-Use Disorder Date diagnosed: / Opioid-Use Disorder Date diagnosed: / Chronic Pain (Limited to the following ICD-10 codes): G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 G89.3 Date(s) diagnosed:	В	Please indicate which condition(s) t	the member has and date diagnosed for each:	
Prediabetes Date diagnosed:// History of Falls/or Hip Fracture Date diagnosed:// Opioid-Use Disorder Date diagnosed:// Chronic Pain (Limited to the following ICD-10 codes):		Chronic Kidney Disease	Date diagnosed://	
History of Falls/or Hip Fracture Date diagnosed:/_/ Opioid-Use Disorder Date diagnosed:/_/ Chronic Pain (Limited to the following ICD-10 codes): G89.0 G89.2 G89.2 G89.21 G89.2 G89.22 G89.2 G89.29 G89.2 G89.29 G89.2 G89.21 Date(s) diagnosed:		Diabetes	Date diagnosed://	
Opioid-Use Disorder Date diagnosed: Chronic Pain (Limited to the following ICD-10 codes): G89.0 G89.2 G89.2 G89.21 G89.2 G89.22 G89.2 G89.21 G89.2 G89.22 G89.2 G89.21 G89.2 G89.22 G89.2 G89.23 G89.2 G89.24 G89.2 G89.25 G89.2 G89.20 G89.2 G89.23 G2 Provider National Provider Identifier (NPI):		Prediabetes	Date diagnosed://	
 Chronic Pain (Limited to the following ICD-10 codes): G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 O Date(s) diagnosed: Provider National Provider Identifier (NPI): Physician Name (please print): 		History of Falls/or Hip Fracture	Date diagnosed://	
G89.0 G89.2 G89.21 G89.22 G89.28 G89.29 G89.3 G89.29 Date(s) diagnosed:		Opioid-Use Disorder	Date diagnosed://	
Date(s) diagnosed:		Chronic Pain (Limited to the followi	ing ICD-10 codes):	
D Physician Name (please print):				
	С	Provider National Provider Identifie	er (NPI):	
E Physician Signature:	D	Physician Name (please print):		
	Е	Physician Signature:		

Instructions to provider:

Please complete all fields of this form. By signing this form, you are attesting to the fact you are the patient's medical provider and the information provided is accurate. Upon completion return to: Martin's Point Generations Advantage Enrollment Department PO Box 9746 Portland, ME 04104

Or FAX to 207-828-7818