

Date	Member First Name:	Member Last Name:
Member ID#:	Date of Birth:	Plan Name (refer to your ID card):

- ☐ I attest to the following conditions and would like to request the SSBCI grocery benefit. I understand that my PCP will verify my chronic condition prior to me receiving the benefit.
Fax this form to Clever Care at (657) 220-8227. It may take up to 7 calendar days to process the request.

Chronic Condition Category and Diagnosis

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|--|---|--|
| ☐ Autoimmune disorders | ☐ Chronic heart failure | ☐ HIV/AIDS |
| ☐ Cancer (excluding pre-cancer conditions or in-situ status) | ☐ Chronic kidney disease | ☐ Immunodeficiency and Immunosuppressive disorders |
| ☐ Cardiovascular disorders | ☐ Chronic lung disorders | ☐ Neurologic disorders |
| ☐ Chronic alcohol and other drug dependence | ☐ Conditions associated with cognitive impairment | ☐ Post-organ transplantation care |
| ☐ Chronic and disabling mental health conditions | ☐ Conditions with functional challenges | ☐ Severe hematologic disorders |
| ☐ Chronic gastrointestinal disease | ☐ Dementia | ☐ Stroke |
| | ☐ Diabetes mellitus | |

Qualifying diagnosis: _____