Blue Cross of Idaho

Health Qualification Form

See instructions on back

Member Information *(complete and sign)*

Member Name *(Please print)*		Blue Cross of Idaho Subscriber ID Number *(9-digit number)*	
Date of Birth *(mm/dd/yyyy)*	Sex: ❑ Male ❑ Female	Telephone Number	Chose One: ❑ Employee ❑ Spouse
Employer Group Name **Albertsons-United Division**		Group Number **10032854**	
Member Signature			Date

Healthcare Professional providing this service *(complete and sign)*

Provider Name *(Please print)*	Telephone Number	State License Number or National Provider ID (NPI)
Provider Signature		Date

Healthcare Provider: Please provide your information above and complete the health measures below.

Health Measure	Initial Evaluation			Values (Required)
Smoke Free	Check one ***(required)***:			
	❑ A (25 points)	❑ B (25 points)	❑ C (0 points)	Assessment Date: ____/____/____
	Patient is smoke-free for three consecutive months prior to assessment date	Patient smokes but commits to complete a smoking cessation course within 90 days	Patient declines to quit smoking	
Blood Pressure	Check one ***(required)***:			
	❑ A (15 points)	❑ B (15 points)	❑ C (0 points)	Measurement Date: ____/____/____
	BP < 140/90 if non-diabetic	BP ≥ 140/90 if non-diabetic and patient commits to follow treatment plan	BP ≥ 140/90 if non-diabetic	BP Value: ____/____
Cholesterol *(measured by total cholesterol (TC), TC/high-density lipoprotein ratio or low-density lipoprotein)*	Check one ***(required)***:			
	❑ A (15 points)	❑ B (15 points)	❑ C (0 points)	Measurement Date: ____/____/____
	Total Cholesterol < 200 or TC/HDL is < 5.0 or LDL ≤ 130	Total Cholesterol ≥ 200 or TC/HDL is < 5.0 or LDL > 130 and patient commits to follow treatment plan	Total Cholesterol ≥ 200 or TC/HDL is < 5.0 or LDL > 130 and patient declines to follow treatment plan	Total Cholesterol: _____mg/dl Triglycerides: _____mg/dl HDL: _____mg/dl LDL: _____mg/dl
Weight *(measured by body mass index)*	Check one ***(required)***:			
	❑ A (15 points)	❑ B (15 points)	❑ C (0 points)	Measurement Date: ____/____/____
	BMI ≤ 28	BMI > 28 and patient commits to participate in a weight-loss program to reach goal	BMI > 28 and patient declines to participate in a weight-loss program	BMI: _____ Waist: _____inches Height: _____ft._____ inches Weight: _____lbs.
Blood Sugar *(measured by fasting blood sugar or hemoglobin A1c)*	Check one ***(required)***:			
	❑ A (15 points)	❑ B (15 points)	❑ C (0 points)	Measurement Date: ____/_____
	FBS ≤ 100 or A1c ≤ 5.8 if non-diabetic or A1c < 7 if diabetic	FBS > 100 or A1c > 5.8 if non-diabetic or A1c ≥ 7 if diabetic and patient commits to follow treatment plan	FBS > 100 or A1c is > 5.8 if non-diabetic or A1c is ≥ 7 if diabetic and patient declines to follow treatment plan	❑ Non-diabetic ❑ Diabetic FBS: _____mg/dl OR A1c: _____%
Member follow-up: ❑ 3 months ❑ 6 months ❑ 1 year ❑ as needed				**Members total points**_____ *(85 points possible, need 65 to pass)*

Make a copy of this completed form and keep for your records.

WELL CONNECTED® A healthier you starts here

Instructions to Member: Please complete and sign your portions of this form and obtain the necessary information and signature from your healthcare provider. **Refer to your Blue Cross of Idaho identification card.**

Mail the completed form to the address below. If you return this form and score 65 points or more and complete the online personal health assessment at ***bcidaho.com***, you can save up to $900 on your June 2017 - May 2018 medical program contribution. Your discount is prorated based on your qualification date.

Instructions to Healthcare Provider: Please check the appropriate box for each health measure located on the chart on the front of this form. Include dates, readings, comments under the "Values" section below. Then total the points, sign this form, and give the completed form back to your patient. **Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.**

Note to Member: We are committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible Team Members. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 866-283-6808 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. The information from your Health Qualification Form is strictly confidential and will not be shared with your employer. Blue Cross of Idaho will only inform your employer of your qualification status.

Source: Blue Cross of Idaho bases ranges on clinical guidelines available to members and providers on the Blue Cross of Idaho website at ***bcidaho.com.***

Questions about this form?
Contact Blue Cross of Idaho Customer Service by phone at 866-283-6808
or email inquiries to: **CustomerService@BCIdaho.com**

Mail a copy of completed form to:
Blue Cross of Idaho, Attn: WellConnected/HQF, P.O. Box 7408, Boise, ID 83707-1408
or Fax Toll Free to: 800-471-4424 or Scan & Email to: *wellconnected@bcidaho.com*

Reminder to Healthcare Professionals: Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.

This information is confidential and your results will not be shared with the Albertsons-United Division.

The signed parties agree that all of the information supplied is complete and accurate.