Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Care Network Qualification Form

What to do

The *Blue Care Network Qualification Form* is on Page 2. It applies to members who are part of:

- Healthy *Blue* Living℠ HMO
- Healthy *Blue* Living HMO Basic℠
- BCN Wellness Rewards Tracking℠

Complete the *Member Section*, then give the form to your primary care provider as a reminder for them to submit your form online. **Online submission of your qualification form is due within the first 90 days of your plan year.** Your deadline date is posted on your to-do list in your online member account at **bcbsm.com.** See below.

You don't need to wait until your new plan year starts to see your doctor. We'll accept a qualification form from an office visit that occurred up to 180 days before the start of your plan year.

Learn your requirements, deadline dates and more about your coverage

You have certain tasks to complete within specific timeframes. **Here's how you can check what requirements you need to do, your deadline dates and coverage:**

- Refer to the *Welcome Book* you received in the mail.
- Save the letters you receive from BCN about the requirements and deadlines specific to you.
- Check your to-do list, requirements and deadlines in your account.
    - Log in to your account at **bcbsm.com** using your computer or the web browser on your mobile device or tablet. (Your to-do list is not available through our mobile app.)
        - Click *My Coverage* in the navigation menu.
        - Click *Medical* from the drop-down menu.
        - Click *To-do List*.

If you have questions, call the Customer Service number on the back of your BCN member ID card.

Important: The qualification form shows that a cotinine test is required. A cotinine test checks for tobacco use. Some members may not be required to complete the cotinine test — see your member materials for information.

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to be submitted electronically by your primary care provider

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Member section:

Last name	First name	Date of birth (MM/DD/YYYY)

Contract/enrollee ID number	Gender: ☐ Female ☐ Male	Ethnicity (optional): ☐ Arab American ☐ Asian American ☐ Black not Hispanic ☐ Chaldean ☐ Hispanic ☐ Multiracial ☐ North American Native ☐ White not Hispanic ☐ Other
Telephone number		

BCN primary care provider: Take notes on this form, and input the data into Health e-Blue℠. Refer to Health e-Blue for standards of care. If you have any questions, contact your BCN provider representative. Give a copy of the electronic *Certificate of Submission* or a completed and signed copy of the paper form to the member, and keep a copy with the member's medical records. Tip: If you arrange for the member to receive laboratory tests in advance of the physical exam, you may be able to complete the form during the office visit.

Scoring key:
A = Member meets criteria
B = Member commits to treatment plan
C = Member does not commit

Visit date (MM/DD/YYYY)

Criteria	Score	Current results
Tobacco Does not use (never used or quit >1 month with cotinine levels of <10 ng/mL for serum or <100 ng/mL for urine)	☐ A. Does not use tobacco ☐ B. Tobacco user: Commits to enroll in or is enrolled in BCN-designated tobacco-cessation program ☐ C. Tobacco user: Does not commit to and is not enrolled in BCN-designated tobacco-cessation program	Cotinine test: After one negative test, no testing needed in future years; test not needed for self-reported tobacco users ☐ Blood ☐ Urine ☐ Positive ☐ Negative Date of cotinine test: _____ Cotinine level: _____ ng/mL
Weight Body mass index <30 kg/m^2	☐ A. BMI <30 ☐ B. BMI is ≥ 30: Commits to enroll in a BCN-sponsored weight-management program ☐ C. BMI is ≥ 30: Does not commit to enroll in a BCN-sponsored weight-management program	Date height and weight measured: _____ Height: _____ (feet) _____ (inches) Weight (pounds): _____ BMI: _____
Blood pressure <140/90 mmHg	☐ A. Does not have high blood pressure or it is controlled ☐ B. Has high blood pressure that is not controlled but is following treatment ☐ C. Has high blood pressure; does not commit to or is not following treatment	Systolic: _____ Diastolic: _____ Date of blood pressure reading: _____
Cholesterol LDL target level based on risk factors: <100, <130 or <160	☐ A. Does not have high cholesterol or it is well controlled ☐ B. Has high cholesterol that is not controlled but is following treatment or does not tolerate treatment ☐ C. Has high cholesterol; does not commit to or is not following treatment	Total cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____ Date of cholesterol test: _____
Blood sugar Fasting blood sugar or A1C **Non-diabetic:** FBS <126mg/dL A1C <6.5% **Known diabetic:** A1C goal <8%	☐ A. Does not have diabetes or A1C is well controlled ☐ B. A1C is not controlled but is following treatment ☐ C. A1C is not controlled; does not commit to or is not following treatment	☐ **No known diabetes** FBS: _____ mg/dl A1C: _____ ☐ **Known diabetes** A1C: _____ Date of A1C or FBS test: _____
Depression Any depression is in full remission	☐ A. Does not have either history or current symptoms of depression ☐ B. Has depression and is following treatment ☐ C. Has depression and does not commit to or is not following treatment	Date of PHQ-2 or PHQ-9 test: _____ PHQ-2 score: _____ PHQ-9 score: _____

Provider's approval: I verify the information supplied is complete and accurate.

Health care provider's last name	Health care provider's first name	National provider identifier, or NPI
Health care provider's signature	**Health care provider's telephone number**	**Date**