Blue Cross Blue Shield of Michigan

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

Qualification Form Standard

2025.Stnd.v1 *BCBSM use only*

Member Section

Member instructions:
Complete the top section of this form and take it to your physician to complete the bottom section. Be sure you receive a copy of the completed form to keep for your records.

Exam date (mm/dd/yyyy)

Member last name	Member first name	
Contract or enrollee ID number (example: 123456789)	Group number (five- or nine-digit number)	
Daytime telephone number	Date of birth (mm/dd/yyyy)	Gender (Check one) ☐ Male ☐ Female
Member signature	Member email address	

Physician Section

Physician instructions:
Please complete the exam date section in the top right corner and the designated fields below. If the patient's measurement does not meet the listed criteria, please check the box to the right of the section to indicate that the patient is working to improve the missed measurement. **To submit this form, follow the instructions on the back.**

Health measure criteria (Do not write in this column)	Patient's measurements (Write measures in these columns)		Check box if measure does not meet criteria but working to improve
Tobacco Patient reports never used tobacco or quit > 1 month **Cotinine test is not required**	☐ Tobacco User ☐ Non-tobacco User		☐
Weight Body mass index < 30 kg/m^2	Height: (feet) Weight: (lbs)	Height: (inches) BMI:	☐
Blood pressure < 140/90 mm/Hg	Systolic:	Diastolic:	☐
Cholesterol LDL < 160 mg/dL HDL > 40 mg/dL Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL	LDL: Total cholesterol:	HDL: Triglycerides:	☐
Blood sugar Patients without diabetes, FBS < 126 mg/dL or Patients with diabetes, A1C < 8%	FBS - patients without diabetes:	A1C - patients with diabetes:	☐

Physician signature: I verify the information supplied is complete and accurate.

Physician last name	**Physician first name**	**National provider identifier**
Physician signature	**Physician telephone number**	**Date** (mm/dd/yyyy)

Questions? Call toll-free, 1-800-775-BLUE (2583) Mon – Fri, 8 a.m. – 5 p.m. EST/EDT

BCBSM Qualification Form
(this side for physician office use only)

Physician Instructions

1. If the patient does not meet one or more of the health measure criteria listed on the front page, you may document a Health Improvement Plan below. The Health Improvement Plan does not have to be faxed to Blue Cross.
2. Please give a completed and signed copy of this form to the patient to keep for their records. You should also keep a copy with the patient's medical records.
3. Michigan providers may complete this form online. Log in to our provider portal at **availity.com**. Click *Payer Spaces*, click *BCBSM BCN* and then click the tile for the *BCBSM Qualification Form*. You will be routed to an online form for submission.
4. Providers who can't complete the form online may fax the form to Blue Cross Blue Shield of Michigan at **1-866-392-6496**. Please wait for a fax receipt and place in the patient's medical records with a copy of the completed form.

Health Improvement Plan

This Health Improvement Plan is between the health care provider and patient and should not be faxed to Blue Cross. This Health Improvement Plan is not a Physician Verification Form.

The Health Improvement Plan should include:

- ☐ Goals
- ☐ Patient actions to modify behavior, lifestyle or adherence to medical recommendations
- ☐ Follow up visit plan established in accordance with physician recommendations

Health measure	Normal health measure guidelines	Goals for patient
Tobacco	Patient reports never used tobacco or quit > 1 month	
Weight	BMI < 30 kg/m^2 (normal BMI 18.5 – 24.9, overweight BMI 25.0 – 29.9)	
Blood pressure	< 140/90 mm/Hg (normal < 120/80, pre-hypertension 120/80 – 139/89) both systolic and diastolic	
Cholesterol	< 100 mg/dL for high risk, < 130 mg/dL for moderate risk, < 160 mg/dL for low risk patients	
Blood sugar	Patients without diabetes: normal fasting blood sugar < 126 mg/dL or A1C < 6.5% Patients with diabetes: A1C < 8%	

Patient actions (document the plan in the member's record):

Frequency of follow up visits: _____ weeks _____ months