



Blue Cross
Blue Shield
of Michigan

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

Qualification Form Standard

2021.Stnd.v1 *BCBSM use only*

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|----------------------------|---|-----------------------------------|--|---|---|
| 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) <input type="checkbox"/> Male <input type="checkbox"/> 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 | | <input type="checkbox"/> Tobacco User | <input type="checkbox"/> Non-tobacco User | <input type="checkbox"/> |
| | Weight Body mass index < 30 kg/m ² | | Height: (feet) | Height: (inches) | <input type="checkbox"/> |
| | | | Weight: (lbs) | BMI: | |
| | Blood pressure < 140/90 mm/Hg | | Systolic: | Diastolic: | <input type="checkbox"/> |
| | Cholesterol LDL < 160 mg/dL HDL > 40 mg/dL Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL | | LDL: | HDL: | <input type="checkbox"/> |
| | | | Total cholesterol: | Triglycerides: | |
| | Blood sugar Patients without diabetes, FBS < 126 mg/dL or Patients with diabetes, A1C < 8% | | FBS - patients without diabetes: | A1C - patients with diabetes: | <input type="checkbox"/> |
| | 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 am – 6 pm EST/EDT

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

Instructions for Michigan physicians

1. If the patient doesn't 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 doesn't have to be submitted 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. To submit the form to Blue Cross, log in to the *Provider Secured Services* page at bcbsm.com and click the link for the *BCBSM Qualification Form*. Then click on *Complete a new Qualification Form* at the left.
4. Enter the information you wrote on the qualification form into the corresponding fields on the electronic form, including member information, exam date and health measures.
5. Once you've entered the doctor's first and last name, national provider identifier and telephone number, click on *Submit as Complete*. You'll either get a message telling you your submission was successful, or a message telling you if there are any errors that require completion or correction. If there are errors, please correct them and click on *Submit as Complete*.

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