Qualification Form Instructions

Congratulations on taking steps toward maintaining or improving your health!

The Blue Cross Blue Shield of Michigan *Qualification Form* is enclosed for you and your physician to complete. Be sure to submit the form in time to meet your plan's deadline. Do not submit any other versions of the *Qualification Form*; only the enclosed form will be accepted. The enclosed sample form shows how to fill out the form.

Here's how to fill out the Member Qualification Form:

1. Complete the Member Information section with either blue or black pen.

2. Make an appointment with your doctor well before the compliance deadline, to complete the rest of the form. An illegible entry or leaving a field blank will make your form invalid. We can process your form only if all sections are complete and your physician has signed the form.

2. After your *Qualification Form* is complete, **fax it to 1-866-392-6496 before the compliance deadline.** Keep your form and your fax confirmation in a safe place, in case you need to resend it.

After you've completed and submitted the member *Qualification Form*, go to **bcbsm.com**, log in to the Member Secured Services, and visit BlueHealthConnection® for more health and wellness resources.

- Complete the Succeed* health assessment to get a tailored health and wellness plan.
- Participate in one of many online health-coaching programs to meet and maintain your health goals.

After your doctor visit, he or she may want to schedule another appointment with you to discuss some of the health measures on your form. If you smoke, please join Quit the Nic, our free smoking-cessation program, by calling 1-800-775-2583.

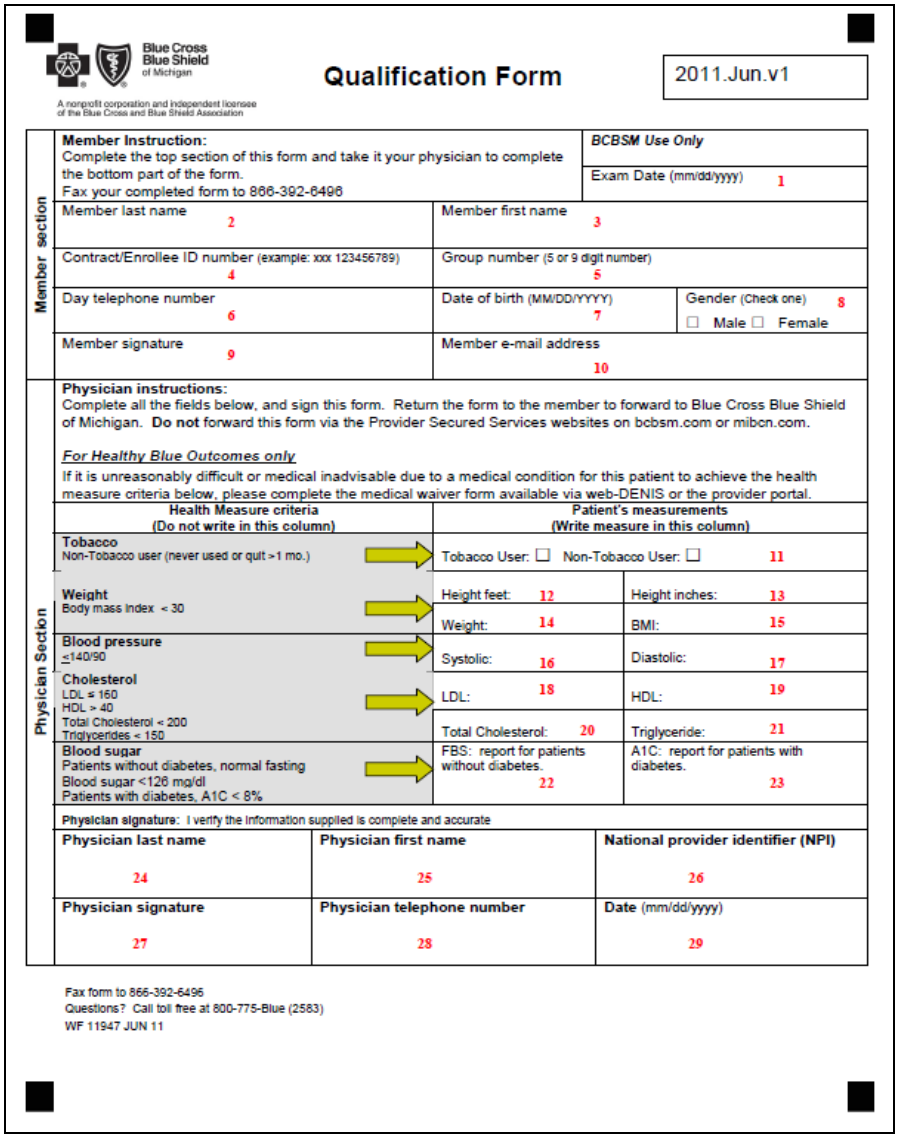
*Health Media Inc.® and StayWell Custom Communications are independent companies partnering with Blue Cross Blue Shield of Michigan to offer Blues members the Succeed™ Health Assessment.

Sample Forms and Instructions

Sample of member ID card:

1. Location of the Contract (Enrollee ID) number
2. Location of the Group Number

Qualification Form instructions. (Please use the official form enclosed.) Sample front of form:



Blue Cross Blue Shield of Michigan

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

Qualification Form

2011.Jun.v1

Member section

Member Instruction:
Complete the top section of this form and take it your physician to complete the bottom part of the form.
Fax your completed form to 866-392-6496

BCBSM Use Only

Exam Date (mm/dd/yyyy) 1

Member last name 2	Member first name 3
Contract/Enrollee ID number (example: xxx 123456789) 4	Group number (5 or 9 digit number) 5
Day telephone number 6	Date of birth (MM/DD/YYYY) 7
Member signature 9	Member e-mail address 10

Gender (Check one) 8 ☐ Male ☐ Female

Physician Section

Physician instructions:
Complete all the fields below, and sign this form. Return the form to the member to forward to Blue Cross Blue Shield of Michigan. **Do not** forward this form via the Provider Secured Services websites on bcbsm.com or mibcn.com.

For Healthy Blue Outcomes only

If it is unreasonably difficult or medical inadvisable due to a medical condition for this patient to achieve the health measure criteria below, please complete the medical waiver form available via web-DENIS or the provider portal.

Health Measure criteria (Do not write in this column)	Patient's measurements (Write measure in this column)	
Tobacco Non-Tobacco user (never used or quit >1 mo.)	Tobacco User: ☐ Non-Tobacco User: ☐ 11	
Weight Body mass index < 30	Height feet: 12	Height inches: 13
	Weight: 14	BMI: 15
Blood pressure <140/90	Systolic: 16	Diastolic: 17
Cholesterol LDL ≤ 160 HDL > 40 Total Cholesterol < 200 Triglycerides < 150	LDL: 18	HDL: 19
	Total Cholesterol: 20	Triglyceride: 21
Blood sugar Patients without diabetes, normal fasting blood sugar <126 mg/dl Patients with diabetes, A1C < 8%	FBS: report for patients without diabetes. 22	A1C: report for patients with diabetes. 23

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

Physician last name 24	**Physician first name** 25	**National provider identifier (NPI)** 26
Physician signature 27	**Physician telephone number** 28	**Date** (mm/dd/yyyy) 29

Fax form to 866-392-6496
Questions? Call toll free at 800-775-Blue (2583)
WF 11947 JUN 11

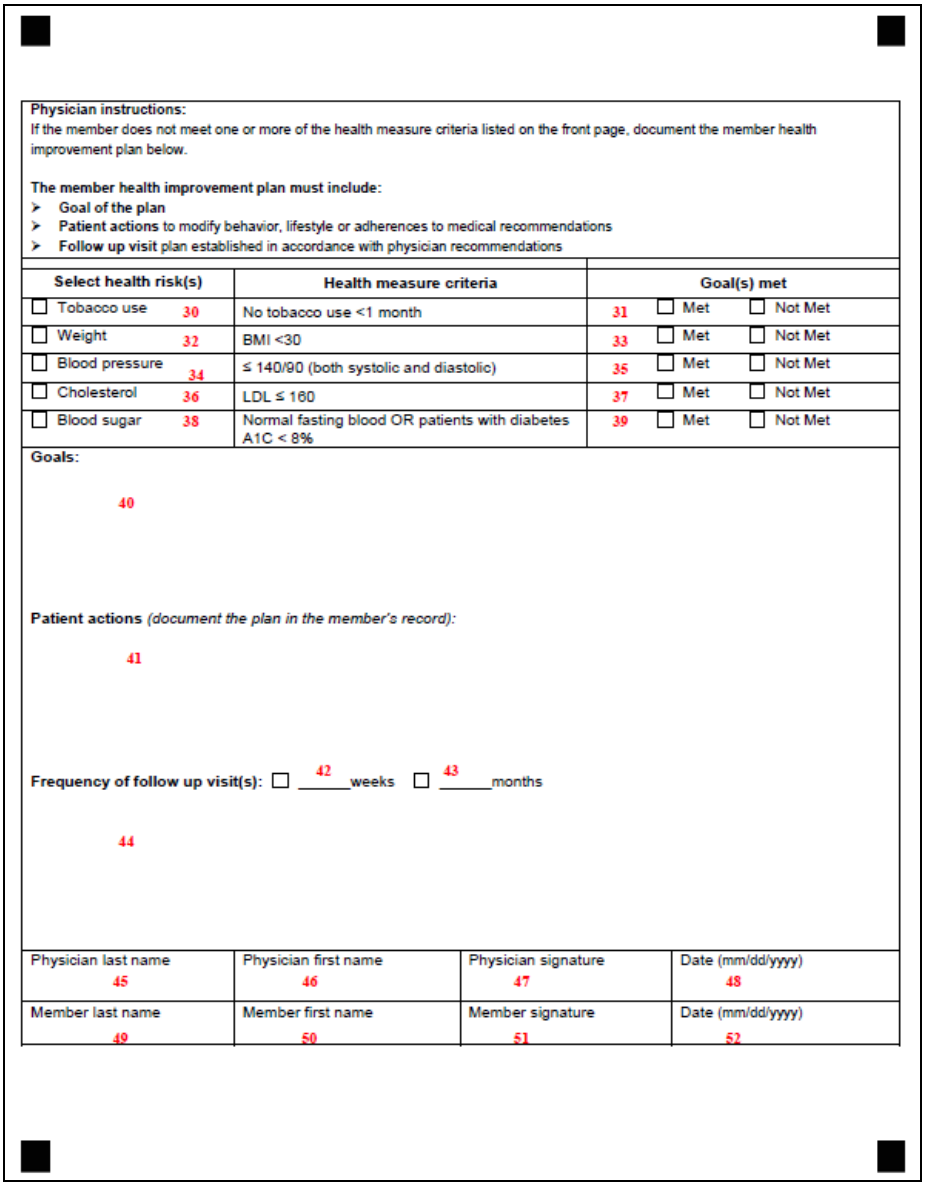
Member instructions for front of form:
Complete boxes 1 through 10. Have your doctor complete 11 through 29.

For boxes 4 and 5, see the sample ID card for the location of the enrollee ID and group numbers.

Make an appointment with your physician. Take the form for the physician to complete.

Physician instructions for front of form:
Complete boxes 11 through 29.

Sample back of form:



Physician instructions:
If the member does not meet one or more of the health measure criteria listed on the front page, document the member health improvement plan below.

The member health improvement plan must include:
- **Goal of the plan**
- **Patient actions** to modify behavior, lifestyle or adherences to medical recommendations
- **Follow up visit** plan established in accordance with physician recommendations

Select health risk(s)	Health measure criteria	Goal(s) met
☐ Tobacco use 30	No tobacco use <1 month	31 ☐ Met ☐ Not Met
☐ Weight 32	BMI <30	33 ☐ Met ☐ Not Met
☐ Blood pressure 34	≤ 140/90 (both systolic and diastolic)	35 ☐ Met ☐ Not Met
☐ Cholesterol 36	LDL ≤ 160	37 ☐ Met ☐ Not Met
☐ Blood sugar 38	Normal fasting blood OR patients with diabetes A1C < 8%	39 ☐ Met ☐ Not Met

Goals:

40

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

41

Frequency of follow up visit(s): ☐ 42 _____weeks ☐ 43 _____months

44

Physician last name 45	Physician first name 46	Physician signature 47	Date (mm/dd/yyyy) 48
Member last name 49	Member first name 50	Member signature 51	Date (mm/dd/yyyy) 52

Physician instructions continued:
Complete boxes 30-48

Member instructions continued:
Complete boxes 49-52

Fax the completed form to the fax number on the form.

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Exam Date (mm/dd/yyyy)

Member last name	Member first name	
Contract/Enrollee ID number (example: xxx 123456789)	Group number (5 or 9 digit number)	
Day telephone number	Date of birth (MM/DD/YYYY)	Gender (Check one) ☐Male ☐Female
Member signature	Member e-mail address	

Physician Section

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Weight Body mass index < 30 →	Height feet:	Height inches:
	Weight:	BMI:
Blood pressure ≤140/90 →	Systolic:	Diastolic:
Cholesterol LDL ≤ 160 HDL > 40 Total Cholesterol < 200 Triglycerides < 150 →	LDL:	HDL:
	Total Cholesterol:	Triglyceride:
Blood sugar Patients without diabetes, normal fasting Blood sugar <126 mg/dl Patients with diabetes, A1C < 8% →	FBS: report for patients without diabetes.	A1C: report for patients with diabetes.

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

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

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Select health risk(s)	Health measure criteria	Goal(s) met
☐ Tobacco use	No tobacco use <1 month	☐ Met ☐ Not Met
☐ Weight	BMI <30	☐ Met ☐ Not Met
☐ Blood pressure	≤ 140/90 (both systolic and diastolic)	☐ Met ☐ Not Met
☐ Cholesterol	LDL ≤ 160	☐ Met ☐ Not Met
☐ Blood sugar	Normal fasting blood OR patients with diabetes A1C < 8%	☐ Met ☐ Not Met

Goals:

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

Frequency of follow up visit(s): ☐ _____weeks ☐ _____months

Physician last name	Physician first name	Physician signature	Date (mm/dd/yyyy)
Member last name	Member first name	Member signature	Date (mm/dd/yyyy)