

Member instructions for qualification form

Your **Blue Care Network Qualification Form** is on Page 2. Complete the "Member section," then give the form to your primary care physician during your physical to remind him or her to submit your form. Your doctor will take your member information and submit your qualification form online. Online submission of your qualification form is due 90 days from the start of your plan year.

You don't need to wait until your new plan year starts to have your Healthy *Blue Living*SM HMO physical. We accept qualification forms up to 180 days old.

Check that we've received your form by logging in to your account at **bcbsm.com** and clicking on *My Coverage*. Or call the Customer Service number on the back of your Blue Care Network ID card.

Taking these steps will help you earn lower out-of-pocket costs:

You'll need to:		Due:
1.	Visit your primary care physician to complete the qualification form.	90 days from your plan year's start
2.	Take the health assessment by logging in as a member at bcbsm.com .	
3.	Based on your qualification form, you may have more requirements: <ul style="list-style-type: none"> • <i>If you use tobacco</i>, enroll in our tobacco-cessation program. Participate through the end of your plan year or until we have an updated qualification form from your doctor stating you do not use tobacco. • <i>If your body mass index is 30 or higher</i>, enroll in BCN's weight-management program. Participate through the end of your plan year or until we have an updated qualification form from your doctor showing your BMI is below 30. 	120 days from your plan year's start

For details and a downloadable qualification form, visit **bcbsm.com**. Or call the Customer Service number on the back of your ID card.

Blue Care Network is committed to helping you achieve your best health status. Rewards for participating in our wellness program, Healthy *Blue Living*, are available to all contract holders who meet all qualification requirements. If you think you might be unable to meet a standard or requirement for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. You can work with your Blue Care Network primary care physician to find an alternative that is right for you in light of your health status.

Consult with your primary care physician before starting any regular exercise or weight-management program.

Blue Care Network Qualification Form

to be submitted electronically by your primary care physician



Member section:

Last name		First name		Date of birth (MM/DD/YYYY)	
Contract/enrollee ID number			Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Ethnicity (optional): <input type="checkbox"/> Arab American <input type="checkbox"/> Asian American <input type="checkbox"/> Black not Hispanic <input type="checkbox"/> Chaldean <input type="checkbox"/> Hispanic <input type="checkbox"/> Multiracial <input type="checkbox"/> North American Native <input type="checkbox"/> White not Hispanic <input type="checkbox"/> Other
Telephone number					

BCN primary care physician: Take notes on this form, and input the data into Health e-BlueSM. 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)	<input type="checkbox"/> A. Does not use tobacco <input type="checkbox"/> B. Tobacco user: Commits to enroll in or is enrolled in BCN-designated tobacco-cessation program <input type="checkbox"/> 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 <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date of cotinine test: _____ Cotinine level: _____ ng/mL
Weight Body mass index <30 kg/m ²	<input type="checkbox"/> A. BMI <30 <input type="checkbox"/> B. BMI is ≥ 30: Commits to enroll in a BCN-sponsored weight-management program <input type="checkbox"/> 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	<input type="checkbox"/> A. Does not have high blood pressure or it is controlled <input type="checkbox"/> B. Has high blood pressure that is not controlled but is following treatment <input type="checkbox"/> 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	<input type="checkbox"/> A. Does not have high cholesterol or it is well controlled <input type="checkbox"/> B. Has high cholesterol that is not controlled but is following treatment or does not tolerate treatment <input type="checkbox"/> 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%	<input type="checkbox"/> A. Does not have diabetes or A1C is well controlled <input type="checkbox"/> B. A1C is not controlled but is following treatment <input type="checkbox"/> C. A1C is not controlled; does not commit to or is not following treatment	<input type="checkbox"/> No known diabetes FBS: _____ mg/dl A1C: _____ <input type="checkbox"/> Known diabetes A1C: _____ Date of A1C or FBS test: _____
Depression Any depression is in full remission	<input type="checkbox"/> A. Does not have either history or current symptoms of depression <input type="checkbox"/> B. Has depression and is following treatment <input type="checkbox"/> 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: _____

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

Physician's last name	Physician's first name	National provider identifier, or NPI
Physician's signature	Physician's telephone number	Date