Clinician Health Review Form For Employees

MASSACHUSETTS

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It pays to be healthy

PATIENT INFORMATION

Form(s) Due Date: 09/30/2017	DOB: 10/01/1982	BCBS Group #: 006854918
Last Name: MCDANIEL	First Name: MATTHEW	Member ID #: 982050152
Gender: MALE	Phone Number: 000-000-0000	Account #: 8054888

INSTRUCTIONS FOR CLINICIANS

In order for your patient to receive their incentive please fill in the last normal value within recommended screening time frames (as recommended by the U.S. Preventive Services Task Force or other national standard). If no current value is available, or if the patient has not received the recommended screenings, please perform them prior to including the values in this form.

How to document patient progress and bill for completing the Clinician Health Review Form:
Complete the Initial Assessment part of this form using the patient's most recent data.

If the patient is:	Then the patient:	And you should:
Within range for all measures	- Is eligible for the total incentive after he or she submits the Initial Assessment Form	- Complete and sign the Initial Assessment Form - Bill Blue Cross Blue Shield using CPT code 99420
Out of range on any measure	- Is eligible for a partial incentive after he or she submits the Initial Assessment Form - To receive the remaining incentive, he or she must work with you to set a health goal, and meet that goal prior to the due date above	- Set a health goal with the patient. At the time when the patient's goal is set, if you set an outcome-based goal (for example, to lose fifteen pounds), the patient may request a reasonable alternative that is participation-based (for example, to engage in a walking program or maintain a food diary) - Complete and sign the Initial Assessment Form - Complete the Follow-up Form prior to the due date above - Bill Blue Cross Blue Shield for completing the Follow-up Form using CPT code 99420 **Note:** You may submit two claims annually for each patient; one for completing the Initial Assessment, and one for completing the Follow-up Form

* For a copy of an age-based schedule of recommended preventive screenings for healthy adults based on those guidelines, go to http://www.bluecrossma.com/common/en_US/pdfs/New_SOB/50-0057_Adult_Screening_Guidelines.pdf

INSTRUCTIONS FOR PATIENTS

Before submitting your Clinician Health Review Form, please make sure your clinician:

- Included values for **ALL FIELDS** on the form
- Documented a health goal, if necessary
- Documented achievement of the health goal (Follow-up Form only)
- Signed and dated the form

It's your responsibility, as the patient, to fax the form by the due date above to **1-855-232-9157** or to mail it to: Healthy Actions c/o IncentiSoft Solutions, One International Place, 20445 Emerald Parkway Dr. SW, Suite 400, Cleveland, OH 44135

Questions? Please call Healthy Actions customer service at 1-855-358-1395.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information will be subject to criminal penalties applicable to state laws.

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Please fax this form to **855-232-9157**

Questions? Please call **855-358-1395**

Clinician Health Review Form

Initial Assessment

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Complete the Initial Assessment for all Healthy Actions Plan patients. Return the completed form to the patient and keep a copy for your records.

PATIENT INFORMATION

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Last Name: MCDANIEL | First Name: MATTHEW | Member ID #: 982050152

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FOR HEALTHCARE PROVIDER USE ONLY: Values in ALL FIELDS are required for your patient to receive their reward

BMI

Height: ____ Ft ____ In ○ 1/4 ○ 1/2 ○ 3/4 ○ even Weight: ____ lbs

Waist Measurement: ____ In ○ 1/4 ○ 1/2 ○ 3/4 ○ even BMI: ____ . ____ **Date Obtained:**_____

BLOOD PRESSURE

Blood Pressure: ____ / ____ **Date Obtained:**_____

(Systolic) (Diastolic)

CHOLESTEROL

Total Cholesterol: ____ LDL Cholesterol: ____ Total Cholesterol/HDL Ratio: ____ . ____

HDL Cholesterol: ____ Triglycerides: ____ **Date Obtained:**_____

GLUCOSE (one or both)

HbA1c: ____ . ____ FBS (Fasting Blood Sugar): ____ **Date Obtained:**_____

TOBACCO USE

Tobacco Use? ○ Yes ○ No **Date Obtained:**_____

PREVENTATIVE SCREENINGS (Has the patient received the following screenings?)

Breast Cancer? ○ Yes ○ No ○ N/A **Date Obtained:**_____ Cervical Cancer? ○ Yes ○ No ○ N/A **Date Obtained:**_____

Colon Cancer? ○ Yes ○ No ○ N/A **Date Obtained:**_____

CLINICIAN: PLEASE SELECT ONE OF THE OPTIONS BELOW AND SIGN BOTTOM OF FORM

○ I attest that my patient is up-to-date (within recommended timeframes) on the screenings and tests above and within acceptable ranges for all.

○ I attest that my patient is up-to-date (within recommended timeframes) on the screenings and tests above and will be working on the following health goal:

Goal to be achieved by the date at the top of the form (e.g. lose weight): **PLEASE PRINT CLEARLY & EXPLAIN AS NECESSARY**	Measurement Target (if applicable, e.g. 135 lbs., walk 3 times per week): **PLEASE PRINT CLEARLY**

Provider Signature:_____ **Date:** ____ (Month) ____ (Day) ____ (Year)

Printed Name:_____

Once the Initial Assessment form is complete and signed, please return it to the patient for submission.

Please fax this form to **855-232-9157** Questions? Please call **855-358-1395**

369964 Form ID: CHR-HA

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