TOTAL HEALTH MANAGEMENT ASSESSMENT FORM

BlueCross BlueShield of Montana

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

SECTION I: Member Information (MEMBER COMPLETES - Please Print)

See reverse side for instructions

Last Name ______________________ First Name ______________________ MI ________ Phone ______________________

Home Address ______________________ City ______________________ State ________ Zip ______________________

Employer ______________________ Date of Birth (mm/dd/yyyy) ______________________ Gender: ❑ Male ❑ Female

Health Plan ID REQUIRED (On ID Card) ______________________ Group Number (On ID Card) ______________________

EMAIL REQUIRED
(A confirmation will be sent to this address)

SECTION II: Primary Care Provider (PCP) Information (MEMBER COMPLETES - Please Print)

See reverse side for definition of PCP

Primary Care Provider (PCP): Last Name ______________________ First Name ______________________

Provider City, State ______________________ Provider Phone Number ______________________

SECTION III: Health Screening Measures (PRIMARY CARE PROVIDER and/or ADDITIONAL PROVIDER(s) COMPLETE)

	HEALTH MEASURE	STANDARD	THM MEASUREMENT FREQUENCY	CURRENT RESULTS	NOT APPLICABLE* *(Comment Required)*
ADULT - *(Age 18 and Older)*					
1	CURRENT TOBACCO USE *(Includes smoke and smokeless tobacco)*	Tobacco Free	Continuous	❑ No, the patient does not use tobacco *(Must have quit 30+ days prior to this screening)* ❑ Yes, the patient does use tobacco	❑
2	BLOOD PRESSURE	≤130/80 mmHg	Annually	/ mmHg	❑
3	CHOLESTEROL	LDL<130 mg/dL	1 to 5 years	LDL: mg	❑
4	WEIGHT		Annually	Lbs.	❑
5	HEIGHT		Annually	Ft. In.	❑
6	BODY MASS INDEX (BMI)	18.5-25.9	Annually		❑
7	COLORECTAL CANCER SCREENING	Colonoscopy *(Age 50-75)* ***or***	10 years	*Current:* ❑ Y ❑ N	❑
		Flexsig or BE *(Age 50-75)* ***or***	5 years		
		FOBT *(Age 50-75)*	Annually		
8	CERVICAL CANCER SCREENING *(Female)*	Pap Test *(Age 21-65)*	3 to 5 years	*Current:* ❑ Y ❑ N	❑
9	BREAST CANCER SCREENING *(Female)*	Mammography *(Age 40 and older)*	1 to 2 years	*Current:* ❑ Y ❑ N	❑
CHILD - *(Age 2-17)*					
10	CHILD TO TEEN BMI *(Age 2 to 17 Percentile)*	Between 0 and 84.9 percentile	Annually	%	❑
11	CHILDHOOD IMMUNIZATIONS	Up to date	Annually	❑ Yes ❑ No	❑

***NOT APPLICABLE COMMENTS:** If your patient's individual circumstances render a health measure inapplicable, please mark that standard as N/A and provide a reason here. *(Indicate line item)*

SECTION IV:

PRIMARY CARE PROVIDER SIGNATURE	DATE
MEMBER SIGNATURE* *(Parent or Guardian signature if member is under 18 years of age)*	DATE

*By signing above, I verify that I have reviewed the information provided by my Provider(s) and agree with the status indicated. I authorize the release of this information to Blue Cross and Blue Shield of Montana.

BLUE CROSS AND BLUE SHIELD OF MONTANA RESERVES THE RIGHT TO AUDIT THE FINDINGS REPORTED ON THIS FORM.

For the purpose of the Total Health Management (THM) program, and to define who can sign the THM form for members, Primary Care Providers (PCP) include the following: Family Medicine, General Practice, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Certified Nurse Midwife, Naturopath, Nurse Practitioner, and Physician Assistant specializing in primary care.
Do not complete this form if you are a Health Screen Vendor.

MEMBER INSTRUCTIONS

By participating in the Total Health Management (THM) program, you may be eligible for an incentive as determined by your employer. By participating in this health screening, I understand that:

- My Group Health Plan may be administered and/or insured by my Employer or an insurance company such as BCBSMT, one of these entities or their selected vendor may have access to my individually identifiable information for condition management and lifestyle management purposes, or to appropriately operate or adminster my Group Health Plan.
- My Employer may receive protected health information related to my participation in any health or wellness program for administration of employee incentive programs.
- It is my responsibility to follow up with my personal physician for results outside of the normal range or if I have any questions or concerns regarding my health.

It is important to complete the following steps:

1. **Schedule your preventive exam** with your Primary Care Provider (PCP). Any services performed will be covered only according to your applicable plan.
2. **Complete Sections I and II.** Your email, phone number, and home address are used to 1) confirm your form has been successfully received and 2) validate form information, if necessary.
3. **Section III.** During your preventative exam, your PCP must complete Section III in its entirety.
4. **Sign and date Section IV with your PCP.**
   a. The form only requires one PCP signature.
   b. Provide your PCP with all personal health metrics not performed by your PCP prior to signature so all health information can be reviewed.
   c. If you use a health screening vendor to obtain some of these results, take the results to your PCP for review.
5. **Retain a completed copy** of the THM Health Assessment Form for your records.
6. **Submit your form.**
   a. Submit one form for each covered member. If your company includes spouses and/or children in their THM program, complete a separate form for each.
   b. Do not attach proof of records with your THM form. All required information is documented on the form. Your PCP should have all your personal health records.
   c. Complete all sections of the form before submission to ensure proper processing. Incomplete forms may be considered invalid and will not be entered.
   d. After the form is completed and signed, please fax to secure fax number (406) 437-7848 or mail the form(s) to: Blue Cross and Blue Shield of Montana, Attn: THM, P.O. Box 4309, Helena, MT 59604-4309.

For questions: Contact your Human Resources Office or email the BCBSMT Wellness Team at Wellness@bcbsmt.com.

Note: Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your employer's wellness program coordinator, sponsor, or Human Resources office and they will work with you to find a wellness program with the same reward that is right for you in light of your health status.

PROVIDER INSTRUCTIONS

Follow these steps when completing this form:

1. **Complete Section III, Health Screening Measures.** Complete all metrics and fields as applicable.
2. **Sign and date Section IV, Signature.** You and your patient must sign this form, even if you have determined an office visit is not required.

   Note: Your signature indicates that you have attended to your patient's overall preventive care. While other providers may have provided portions of the data for the form, your signature implies you've reviewed the preventive measure results and discussed the findings/recommendations with your patient.
3. **Select 'Not Applicable'** if your patient's individual circumstances render a health measure inapplicable, please mark that standard as N/A and provide a reason in the comments section. For instance, if your patient has had a hysterectomy, the standard cervical cancer screening would be inapplicable; mark N/A for the cervical cancer screening standard and in the comment section note that your patient has had a hysterectomy.
4. **Submit your claim** as you normally would with services rendered including CPT®Code 99420. Any services performed will be covered only according to your provider arrangement with BCBSMT and the applicable plan.
5. **Contact Provider Relations** at 1-800-447-7828 or 406-437-6100 with any questions.