Health and Wellness Evaluation Form

See page 2 for instructions.

HealthyBlue

CareFirst
The CareFirst BlueCross BlueShield family of health care plans.

Section I: Member/Provider Information – to be completed by Member and Provider.

Member Information — Completed by Member Please print.		Provider Information — Completed by Provider Please print.
Last Name **First Name** **MI**		**Provider Name**
Member ID Number (found on ID card)		**Provider ID Number**
Date of Birth (mm/dd/yyyy) / /	**Gender** (Check one) ☐ Male ☐ Female	**Provider Phone Number**
Group Number (found on ID card)		**Effective Date of Coverage** (verify in CareFirst Direct or call 1-800-676-BLUE outside of MD, DC, N. VA)

Section II: Health Measures – Completed by Provider

1. Tobacco Use (required for ages 18 and older)

Recommendation: Non-smoker (never smoked or quit for more than 30 days)

Date measured (mm/yyyy): / ☐ Non-Smoker ☐ Smoker

2. Blood Pressure (required for ages 18 and older)

Recommendation: 120/80

Date measured (mm/yyyy): / BP Reading: _____/_____

3. Cholesterol (LDL) (required for ages 18 and older)

Recommendation: Acceptable LDL per guidelines

Date measured (mm/yyyy): / LDL: _____ ☐ Waive if Pregnant

4. Weight (required for ages 2 and older)

Recommendation: • Adult Body Mass Index (BMI) is 19 to 25 • Child BMI is in the fifth to 85th percentile depending on age and gender

Date measured (mm/yyyy): / Adult BMI: _____ ☐ Waive if Pregnant Child BMI: _____%

5. Flu Shot (required for ages 2 and older)

Recommendation: Within last 18 months

Up-to-date on flu shot? ☐ Yes ☐ No Date of last shot (mm/yyyy): /

6. Immunizations and Screenings

Health Factor	Recommendation	Status	Date of Last Screening
Childhood Immunizations	Children ages 2–17 are up-to-date based on Provider's advice.	Member is up-to-date ☐ Yes ☐ No	N/A
Colon Cancer Screening	Members ages 50 and older screened every 10 years.	Member is up-to-date ☐ Yes ☐ No	(mm/yyyy): /
Cervical Cancer Screening	Women ages 21 and older screened every 3 years.	Member is up-to-date ☐ Yes ☐ No	(mm/yyyy): /
Breast Cancer Screening	Women ages 50 and older screened every 2 years.	Member is up-to-date ☐ Yes ☐ No	(mm/yyyy): /

I hereby certify that the information provided on this form is true and accurate to the best of my personal knowledge and understand that any material misrepresentation(s) will disqualify my dependents, if applicable, and me from receiving any Healthy Reward.

Member Signature **Date**

Provider Signature **Date**

Member Instructions:

- Complete the member information in **Section I** of this form.
- Visit your Provider within 180 days after your effective date with HealthyBlue. **Note: Since the results of tests and screenings may take time, see your Provider within 180 days after your effective date. We recommend visiting your PCP within 120 days of your effective date to allow time to complete and submit the form.**
  - Your Provider may determine an office visit is not necessary if you have completed the required screenings, immunizations and health measures within the timeframe outlined in the *Preventive Services Guidelines*.
- If your Provider determines an office visit is not required, you are responsible for taking a copy of this form to your Provider for completion.
- **You must submit this form within 180 days of your effective date to earn your Healthy Reward.**
- The Healthy Reward is not dependent on your specific test results or health status.

For more health plan information, visit **www.carefirst.com/healthyblue**. You can view our Preventive Services Guidelines at **www.carefirst.com/prevention**. If you do not have Internet access, please call Member Services at the phone number on your HealthyBlue ID card for assistance.

Member Instructions for Submitting this Form

Submit this completed form **within 180 days of your effective date** by logging in to *My Account* at **www.carefirst.com**. Click on "My HealthyBlue Rewards" under *Quick Links* and select "Qualification." Click on "Begin Evaluation" to enter the required information.

You can also submit this form using one of the following methods:

- Scan and save this form in JPG, PDF or TIFF format. Login to *My Account* at **www.carefirst.com** and click on "My HealthyBlue Rewards" under *Quick Links*. Click on "Upload your Health and Wellness Evaluation Form" to browse for your document and upload it.
- Fax to 800-354-8205.
- Mail this form to:
  Mail Administrator
  P.O. Box 14116
  Lexington, KY 40512-4116

Provider Instructions:

- Complete the Provider information in **Section I** and verify the member's effective date of coverage. For local plans, use CareFirst Direct. For out-of-area (outside of MD, DC or N. VA), use 1-800-676-BLUE.
- Complete **Section II** in its entirety.
- You must determine whether an office visit is necessary. If your patient has completed the required screenings, immunizations and health measures within the recommended timeframes outlined in the *Preventive Services Guidelines* an office visit may not be required. If there is no office visit, complete **Section II** using the patient's most recent information. **Note: Claims for office visits should be submitted through the following:**
  - **In CareFirst area (inside MD, DC, N. VA)—Submit to CareFirst BlueCross BlueShield.**
  - **Out-of-service area (outside MD, DC, N. VA)—Submit to the local BCBS plan.**
- You must sign and date this form, even if you have determined an office visit is not required. Once signed, return the form to the member to submit to CareFirst BlueCross BlueShield.

For complete program details, and to view our *Preventive Services Guidelines*, visit **www.carefirst.com/providershealthyblue**.

To request a printed copy of our *Preventive Service Guidelines*, contact Provider Services at 800-842-5975.