BlueCross BlueShield of Montana

TOTAL HEALTH MANAGEMENT ASSESSMENT FORM

SECTION 1: Member Information (MEMBER COMPLETES - Please Print Legibly)

Last Name _____ First Name _____ MI _____ Phone _____

Home Address _____ City _____ State _____ Zip _____

Employee Wellness Program Employer _____ Date of Birth (mm/dd/yyyy) _____

Gender: ☐ Male ☐ Female I am the: ☐ Employee ☐ Spouse ☐ Domestic Partner ☐ Retiree

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

EMAIL REQUIRED for form receipt confirmation – **PLEASE PRINT LEGIBLY**

SECTION 2: Primary Care Provider (PCP) Information (MEMBER COMPLETES - Please Print Legibly)

See reverse side for definition of PCP

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

Provider City, State _____ Provider Phone Number _____

SECTION 3: Health Screening Measures - REQUIRED (PRIMARY CARE PROVIDER and/or ADDITIONAL PROVIDER(s) COMPLETE)

	HEALTH MEASURE	STANDARD	THM MEASUREMENT FREQUENCY	CURRENT RESULTS	NOT APPLICABLE*
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	*COMMENT REQUIRED FOR MEASURES MARKED N/A ☐
2	**BLOOD PRESSURE**	≤130/80 mmHg	Annually	/ mmHg	☐
3	**LDL 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)**	18.5-24.9	Annually		☐
7	**COLORECTAL CANCER SCREENING – 1 OF 3 MALE AND FEMALE**	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	☐

SECTION 4: REQUIRED

PRIMARY CARE PROVIDER SIGNATURE	DATE
MEMBER SIGNATURE*	DATE

*By signing my name above, I verify that I have reviewed the information provided by my Provider(s) and agree with the status indicated. I have read and understand the Member Instructions on the back of this form that describe what the information will be used for. I authorize the release of this information to Blue Cross and Blue Shield of Montana.

Please review reverse side for form submission instructions.

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

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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 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 Blue Cross and Blue Shield of Montana, and 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 administer 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.

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 1 and 2.** 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 3.** During your preventative exam, your PCP must complete Section 3 in its entirety.
4. **Confirm your PCP has signed the form.**
   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. **Sign and date Section 4 on the form.**
6. **Retain a completed copy** of the THM Health Assessment Form for your records.
7. **Submit your form.**
   a. Submit one form for each covered member. If your company includes spouses or domestic partner in their THM program, complete a separate form for each.
   b. **Do not** attach proof of labs or 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: **Total Health Management**, P.O. Box 7982, Helena, MT 59604-7982.
   e. If faxing, obtain a fax sent report for your records.
   f. Wait up to 5 business days to receive an email confirmation. If you do not receive an email, please email Wellness@bcbsmt.com.

QUESTIONS? Contact your Human Resources Representative 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

Complete the following steps:

1. **Complete Section 3, Health Screening Measures.** Complete all metrics and fields as applicable.
2. **Sign and date Section 4, 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 comment area. 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 area note that your patient has had a hysterectomy.
4. **Contact Provider Relations** at 1-800-447-7828 or 406-437-6100 with any questions.