



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

Health Plan ID REQUIRED (On ID Card) \_\_\_\_\_ Group Number (On ID Card) \_\_\_\_\_

EMAIL REQUIRED for form receipt confirmation – PLEASE PRINT LEGIBLY

Grid of boxes for email address input

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 \_\_\_\_\_

PCP City, State \_\_\_\_\_ PCP Phone Number \_\_\_\_\_

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

Table with 5 columns: HEALTH MEASURE, STANDARD, THM MEASUREMENT FREQUENCY, CURRENT RESULTS, NOT APPLICABLE\* (COMMENT REQUIRED FOR MEASURES MARKED N/A). Rows include Current Tobacco Use, Blood Pressure, Weight, Height, BMI, Depression Screening, Colorectal Cancer Screening, Cervical Cancer Screening, and Breast Cancer Screening.

SECTION 4: REQUIRED

Table for signatures: PRIMARY CARE PROVIDER SIGNATURE, MEMBER SIGNATURE\*, and DATE columns.

\*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.

**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, consistent with applicable state or federal law.
- My employer may receive protected health information related to my participation in any health or wellness program for administration of employee incentive programs, consistent with applicable state or federal law.
- It is my responsibility to follow up with my PCP for results outside of the normal range or if I have any questions or concerns regarding my health.

**Complete the following steps:**

**1 Review, sign and submit the Employer-Sponsored Wellness Program Participation Notice and Consent Form.**

- a. Keep a copy for your records.
- b. 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 4309, Helena MT 59604-4309
- c. Your participation will not be considered valid without this form.

**2 Schedule your Preventive Exam** with your Primary Care Provider (PCP). Any services performed will be covered according to your benefit plan.

**3 Complete Sections 1 and 2 of the THM Assessment Form.** 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.

**4 Section 3** must be completed, in its entirety, by your PCP during your preventive exam.

**5 Confirm your PCP has signed the THM Assessment Form.**

**6 Sign and date Section 4 on the THM Assessment Form.** Ensure all sections are completed to allow for proper processing. Incomplete forms may be considered invalid.

**7 Save a completed copy of the THM Assessment Form** for your records.

**8 Submit your THM Assessment Form.**

- a. Ensure you submitted your Employer-Sponsored Wellness Program Participation Notice & Consent Form prior to submitting your THM Assessment form.
- b. **Do not** attach proof of labs or records. All required information is documented on the form. Your PCP should have your personal health records.
- c. 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 4309, Helena MT 59604-4309
- d. Wait up to 5 business days to receive an email confirmation. If you do not receive an email, please email [TotalHealthManagement@bcbsmt.com](mailto:TotalHealthManagement@bcbsmt.com)

**QUESTIONS? Contact your Human Resources Representative or email the BCBSMT THM Team at [TotalHealthManagement@bcbsmt.com](mailto:TotalHealthManagement@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 standard 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.