BlueCross BlueShield of Montana — **BLUE VALUE** SM

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**

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)

	HEALTH MEASURE	STANDARD	THM MEASUREMENT FREQUENCY	CURRENT RESULTS	NOT APPLICABLE* *COMMENT REQUIRED FOR MEASURES MARKED N/A
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	WEIGHT		Annually	Lbs.	☐
4	HEIGHT		Annually	Ft. In.	☐
5	BODY MASS INDEX (BMI)	18.5-24.9	Annually		☐
6	DEPRESSION SCREENING	Age ≥ 18	Annually or Per Provider	*Current:* ☐ Y ☐ N	☐
7	COLORECTAL CANCER SCREENING – MALE AND FEMALE	Colonoscopy *(Age 50-75)* ***or***	10 years	*Current:* ☐ Y ☐ N	☐
		Flexsig or CT Colonography *(Age 50-75)* ***or***	5 years		
		FIT-DNA *(Age 50-75)* ***or***	3 Years		
		FIT *(Age 50-75)*	Annually		
8	CERVICAL CANCER SCREENING – FEMALE	Pap Test *(Age 21-64)*	3 to 5 years	*Current:* ☐ Y ☐ N	☐
9	BREAST CANCER SCREENING – FEMALE	Mammography *(50-74)*	Biennial	*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.

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

QUESTIONS? Contact your Human Resources Representative or email the BCBSMT THM Team at 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.