

HealthbyChoice IncentivesSM Qualification Form



This form must be completed and submitted by the provider (typically the Primary Care Provider or provider's office) to Priority Health within 90 days of the member's effective date with **HealthbyChoice Incentives**. Failure to submit this form by the due date below will result in the member's insurance benefits being moved from the **Choice** to the **Standard** benefit level.

Due Date: This completed form must be received by Priority Health by _____

SECTION 1 MEMBER INFORMATION <i>(to be completed by member)</i>		
Name (Last, First, Middle Initial)	Contract Number	Last 4 digits of SSN
Date of Birth	Member's Effective Date	
I certify that the information I am providing to my provider is complete and accurate. I also agree to a follow-up plan with my provider, if applicable. I authorize my provider to release this information to Priority Health. All information will be handled confidentially.		
Signed _____		Date _____

The information below can also be completed online in the Provider Center by going to the HealthbyChoice Incentives section.

SECTION 2 HEALTH INDICATORS <i>(to be completed by provider)</i>						
Qualifying results may be used from up to six months prior to the member's effective date.						
	CRITERIA	ACTUAL	DATE	CRITERIA MET		
				YES	NO	
1	Tobacco User ¹	No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2	BMI ²	Less than 30 (exception if pregnant ²)				
3	Blood Pressure	Less than 140/90				

**Proceed to Section 3 if ANY of the three health indicators above are marked "NO" for CRITERIA MET.
Proceed to Section 4 if all three health indicators are marked "YES" for CRITERIA MET.**

SECTION 3 ADDITIONAL REQUIREMENTS					
Qualifying results may be used from up to six months prior to the member's effective date.					
4	Fasting Cholesterol Test	<input type="checkbox"/> Test Completed Date _____	OR	<input type="checkbox"/> Test Ordered (Must be completed by date listed above SECTION 1)	
5	Fasting Blood Sugar or HbA1c Test	<input type="checkbox"/> Test Completed Date _____	OR	<input type="checkbox"/> Test Ordered (Must be completed by date listed above SECTION 1)	
				YES	NO
6	Provider Follow-up Plan Member has agreed to comply with a follow-up plan in all areas where the health indicator criteria were not met.			Date _____	

SECTION 4 PROVIDER SIGN-OFF		
I acknowledge that this member has met the requirements listed above for the HealthbyChoice Incentives plan. I agree to keep a copy of this form in the patient's chart for follow-up and Priority Health audit.		
Provider Group (as it appears on your check)	Phone Number ()	Tax ID#
Provider Name	NPI# (if available)	
Signed	Date	

**Enter data online OR fax completed form to 616 942-0616. Attn: HealthbyChoice MS2005
This is not a billable form.**

¹ Tobacco use includes all forms of tobacco.

² A member who is pregnant can meet the BMI criteria at the provider's discretion. Write "Pregnant" in the "ACTUAL" box and check "YES" for CRITERIA MET.