HealthbyChoice Incentives℠
Qualification Form

All fields are required unless noted.

Please have your provider complete this form and submit it to Priority Health within 90 days of your **Health**byChoice Incentives effective date. If we do not receive the form within 90 days, you will be moved from the Choice to the Standard level of benefits.

Due date: This completed form must be received by Priority Health by: ____________________

Section 1: Member information (to be completed by member)

Last name		First name	Middle initial
Last four digits of Social Security Number ______________	Birth date / /	Contract number	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.

Signature	Date / /

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

Section 2: Health indicators (to be completed by provider)

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	☐ Yes ☐ No			
2	**BMI**[2]	Less than 30 (exception if pregnant)				
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**	☐ Test completed. Date: ______________ or ☐ Test ordered. (must be completed by date listed above in Section 1)		
5	**Fasting blood sugar or HbA1c test**	☐ Test completed. Date: ______________ or ☐ Test ordered. (must be completed by date listed above in Section 1)		
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.	☐ Yes - Date: / /	☐ No

Note to member: These labs may be subject to deductible, coinsurance or copay.

Section 4: Provider sign-off

I acknowledge that this member has met the requirements listed above for the **Health**byChoice Incentives plan.
I agree to keep a copy of this form in the patient's chart for follow-up and Priority Health audit.

Tax I.D. (required for payment)	Provider group (as it appears on your check)	Phone number ( )
Billing provider name		NPI number (if available)
Signature		Date / /

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.

For internal use only
Date received by Priority Health: ______________

Enter data online or fax completed form to 616 942-0616. Attn: **Health**byChoice, MS2005
This is not a billable form.