



A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association

# Qualification Form

<b>Member instructions:</b> Complete this part of the form and take it to your physician to complete. Fax the completed form to (888) 661-0004 or (888) 661-3914.	<b>Exam date</b> <input type="text"/> / <input type="text"/> / <input type="text"/>
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<b>Member last name</b> <input type="text"/>	<b>Member first name</b> <input type="text"/>	
<b>Contract/enrollee ID number (example: ABC 123456789)</b> <input type="text"/>	<b>Group number (5 or 9 digit number)</b> <input type="text"/>	
<b>Day telephone</b> ( <input type="text"/> ) <input type="text"/> - <input type="text"/>	<b>Date of birth (MM/DD/YYYY)</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Gender (Check one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Member signature</b> <input type="text"/>	<b>E-mail address</b> <input type="text"/>	

**Physician instructions:**  
 Complete all the fields below, and sign this form. Return the form to the member for submission to Blue Cross Blue Shield of Michigan. If the member does not meet one or more of the health measure criteria listed below, document the goals and patient actions in the member health improvement plan on the back of this form.

**For Healthy Blue Outcomes only**  
 If it is unreasonably difficult or medically inadvisable due to a medical condition for this patient to achieve the health measure criteria below, please complete the medical waiver form available via web-DENIS or the provider portal.

Health measure criteria	Member's measurements
<b>Tobacco</b> Non-tobacco user (never used or quit > 1 month)	Tobacco user: <input type="checkbox"/> Non-tobacco user: <input type="checkbox"/>
<b>Weight</b> Body mass index < 30	Height: <input type="text"/> feet <input type="text"/> inches      Weight: <input type="text"/> pounds BMI: <input type="text"/>
<b>Blood pressure</b> ≤ 140/90	BP: <input type="text"/> / <input type="text"/>
<b>Cholesterol</b> LDL ≤ 160	LDL: <input type="text"/>
<b>Blood sugar</b> Patients without diabetes, normal fasting blood sugar  Patients with diabetes, A1C < 8%	FBS: <input type="text"/> (nondiabetic) A1C: <input type="text"/> % (diabetic)

**Physician signature:** I verify the information supplied is complete and accurate.

<b>Physician last name</b> <input type="text"/>	<b>Physician first name</b> <input type="text"/>	<b>National provider identifier (NPI)</b> <input type="text"/>
<b>Physician signature</b> <input type="text"/>	<b>Physician telephone number</b> ( <input type="text"/> ) <input type="text"/> - <input type="text"/>	<b>Date</b> <input type="text"/> / <input type="text"/> / <input type="text"/>



**Physician instructions:**

If the member does not meet one or more of the health measure criteria listed on the front page, document the member health improvement plan below.

**The member health improvement plan must include:**

- **Goals of the plan**
- **Patient actions** to modify behavior, lifestyle or adherence to medical recommendations
- **Follow up visit** plan established in accordance with physician recommendations

Select health risk(s)	Health measure criteria
<input type="checkbox"/> Tobacco use	No tobacco use > 1 month
<input type="checkbox"/> Weight	BMI < 30
<input type="checkbox"/> Blood pressure	≤ 140/90 (both systolic and diastolic)
<input type="checkbox"/> Cholesterol	LDL ≤ 160
<input type="checkbox"/> Blood sugar	Normal fasting blood sugar OR patients with diabetes A1C < 8% diabetic

**Goals:****Patient actions:****Frequency of follow-up visits:**

Physician last name <input type="text"/>	Physician first name <input type="text"/>	Physician signature <input type="text"/>	Date □□ / □□ / □□□□
Member last name <input type="text"/>	Member first name <input type="text"/>	Member signature <input type="text"/>	Date □□ / □□ / □□□□