



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 30 empty 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*. 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 with 2 columns: SIGNATURE, DATE. Rows for Primary Care Provider Signature and Member Signature*.

*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

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.

Employer-Sponsored Wellness Program Participation Notice & Consent Form

As a part of the wellness program sponsored by your employer/your spouse's employer, you are offered an incentive to complete a *voluntary* health risk assessment (HRA)/BCBSMT Blue ValueSM Total Health Management Assessment Form through which you will provide information about your health history, health status or both. Your employer/spouse's employer may provide financial or other incentives to participate in the HRA wellness program.

Your participation in the HRA wellness program is voluntary. You are not required to participate in the HRA wellness program. If you decide to participate, and if there are questions in the HRA related to your own family medical history or your own genetic information (these questions, if any, are identified on the HRA), you are not required to answer them in order for the employee to receive any incentive we offer for completion of the HRA.

We'll use the health information you provide to help you. Findings gathered from the HRA will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer health-related services to you.

Your health information is confidential. We are required by law to maintain the privacy and security of your personally identifiable health information. The medical information collected will not be available to your employer/your spouse's employer in a way that allows your employer/your spouse's employer to identify spouse or employee health information. However, we may use aggregate or summary (e.g., de-identified) information from the HRA to design or provide additional health services. Any individually identifiable medical information we obtain through the wellness program will be maintained separate from personnel records, information stored electronically will be secure and confidential, and no information you provide will be used in making employment decisions.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program (including the health plan which it is a part of), and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or our provision of an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program is required to abide by the same confidentiality requirements. We may disclose your information as necessary to respond to a request from you for a reasonable accommodation to allow you to participate in the wellness program, or as expressly permitted by law.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your employer/your spouse's employer.

I acknowledge the above and agree to participate in the wellness program health risk assessment/BCBSMT Blue ValueSM Total Health Management Assessment Form.

Please select: Employee _____ OR Employee Spouse _____

Last Name _____ First Name _____ MI _____

Email Address _____

Health Plan ID (On ID Card) _____ Group Number (On ID Card) _____

Employer Name _____ Date of Birth (mm/dd/yyyy) _____

Signature _____ Date _____

*All fields are required

Please fax to 406-437-7848, secure email to TotalHealthManagement@bcbsmt.com or mail to: Blue Cross and Blue Shield of Montana, Attn: Total Health Management, P.O. Box 4309, Helena MT 59604-4309