Blue Cross of Idaho®

thriveidaho

2016 State of Idaho Employee Healthcare Provider Form

Subscriber Information *(complete and sign)*

Subscriber Name *(Please print)*		Blue Cross of Idaho Subscriber ID Number *(9-digit number)*
Date of Birth *(mm/dd/yyyy)*	Sex: ❑ Male ❑ Female	Telephone Number
Employer Group Name **State of Idaho**		Group Number **10040000**
Subscriber Signature		Date

Healthcare Professional providing this service *(complete and sign)*

Provider Name *(Please print)*	Telephone Number	State License Number or National Provider ID (NPI)
Provider Signature		Date

Healthcare Provider: Please provide your information above and complete the health measures below. If screening(s) are inadvisable a waiver must be completed. Incomplete forms cannot be accepted.

Health Measure	Evaluation	Values (Required)
Patient is tobacco-free	Check one ***(required)***: ❑ Yes ❑ No	Assessment Date: _____
Blood Pressure BP ≤ 140/90	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ BP Value: _____
Cholesterol *(measured by total cholesterol or high-density lipoprotein)* Total cholesterol < 200 or HDL ≥ 40 (male) or 50 (female)	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ Total Cholesterol: _____mg/dl Triglycerides: _____mg/dl HDL: _____mg/dl LDL: _____mg/dl
Triglycerides ≤ 150	Check one ***(required)***: ❑ Yes ❑ No	
Weight *(measured by body mass index or waist circumference)* BMI ≤ 28 or waist ≤ 35 (female) or ≤ 40 (male)	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ BMI: _____ Waist: _____inches Height: _____ft._____ inches Weight: _____lbs.
Blood Sugar *(measured by fasting blood sugar or hemoglobin A1c)* FBS ≤ 110 or A1c ≤ 5.8 if non-diabetic or A1c < 7 if diabetic	Check one ***(required)***: ❑ Yes ❑ No	Measurement Date: _____ ❑ Non-diabetic ❑ Diabetic FBS: _____mg/dl OR A1c: _____%
Subscriber follow-up: ❑ 3 months ❑ 6 months ❑ 1 year ❑ as needed		

This information is confidential and your results will not be shared with your employer. The signed parties agree that all of the information supplied is complete and accurate. Make a copy of this completed form and keep for your records.

Instructions to Subscriber: Please complete and sign your portions of this form and obtain the necessary information and signature from your healthcare provider. If screening(s) are medically inadvisable, please contact Blue Cross of Idaho to obtain a waiver form for your provider to complete. **Refer to your Blue Cross of Idaho health insurance ID card to complete the fields on the front of this form.**
Mail the completed form to the address indicated on this form.

Instructions to Healthcare Provider: Please check the appropriate box for each health measure located on the chart on the front of this form. Include dates, readings, comments under the "Values" section. If screening(s) are medically inadvisable, a waiver must be completed. Then, sign this form and give completed form back to your patient. **Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.**

Confidentiality: Blue Cross protects the confidentiality of your information, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which prohibits anyone from receiving your personal health information without your permission. The information from your Healthcare Provider Form is strictly confidential and will not be shared with your employer. Blue Cross will only inform your employer of your participation status. Blue Cross of Idaho also provides the State of Idaho with collective data about its population as a whole, without individual personal health information. If your test results indicate you may be at risk for a health condition, a health coach will contact you, unless you have opted out of this personal health support.

Note to Subscriber: We are committed to helping you achieve your best health. Rewards for participating in the wellness program are available to all employees who are the subscriber on one of the State of Idaho's group medical plans and active for payroll processing purposes.

Source: Blue Cross of Idaho bases ranges on clinical guidelines available to subscribers and providers on the Blue Cross of Idaho website at ***bcidaho.com.***

Questions about this form?
Contact Blue Cross of Idaho Customer Service by phone at **208-331-8897 or 866-804-2253**
or email inquiries to: **CustomerService@BCIdaho.com**

Subscriber/Participant: Submit your completed form using one of the following methods. Incomplete forms cannot be accepted.

Make a copy of your completed form and keep for your records.

Scan and email to:	**Or fax toll-free to:**	**Or mail to:**
thriveidaho@bcidaho.com	Blue Cross of Idaho Attn: thriveidaho/HQF 800-471-4424	Blue Cross of Idaho Attn: thriveidaho/HQF P.O. Box 7408 Boise, ID 83707

Reminder to Healthcare Professionals: Please submit the claims identifying the preventive visit as a wellness service to ensure the office visit falls under your patient's preventive care benefit.