

Member Information <i>(complete and sign)</i>		
Member Name <i>(Please print)</i>	Blue Cross of Idaho Subscriber ID Number <i>(9-digit number)</i>	
Date of Birth <i>(mm/dd/yyyy)</i>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number
Employer Group Name <b>Payette School District #371</b>	Group Number <b>10003604</b>	
Member Signature		Date

**This program includes health coaching. Please call 855-216-6844 to work with your certified health coach.**

Healthcare Professional providing this service <i>(complete and sign)</i>		
Provider Name <i>(Please print)</i>	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.**

Health Measure	Initial Evaluation	Values (Required)
<b>Tobacco Free</b>	Check one <i>(required)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is tobacco-free for three consecutive months prior to assessment date      Patient uses tobacco	Assessment Date: _____
<b>Blood Pressure</b>	Check one <i>(required)</i> : <input type="checkbox"/> BP < 140/90 <input type="checkbox"/> BP ≥ 140/90	Measurement Date: _____ BP Value: _____
<b>Cholesterol</b> <i>(measured by total cholesterol or low-density lipoprotein)</i>	Check one <i>(required)</i> : <input type="checkbox"/> Total cholesterol < 200 or LDL ≤ 130 <input type="checkbox"/> Total cholesterol ≥ 200 or LDL > 130	Measurement Date: _____ Total Cholesterol: ____mg/dl Triglycerides: ____mg/dl HDL: ____mg/dl                                      LDL: ____mg/dl
<b>Weight</b> <i>(measured by body mass index)</i>	Check one <i>(required)</i> : <input type="checkbox"/> BMI ≤ 28 <input type="checkbox"/> BMI > 28	Measurement Date: _____ BMI: _____ Waist: _____inches Height: _____ft. _____ inches Weight: _____lbs.
<b>Blood Sugar</b> <i>(measured by fasting blood sugar or hemoglobin A1c)</i>	Check one <i>(required)</i> : <input type="checkbox"/> FBS ≤ 100 or A1c ≤ 5.8 if non-diabetic or A1c < 7 if diabetic <input type="checkbox"/> FBS > 100 or A1c > 5.8 if non-diabetic or A1c ≥ 7 if diabetic	Measurement Date: _____ <input type="checkbox"/> Non-diabetic <input type="checkbox"/> Diabetic FBS: ____mg/dl    OR    A1c: ____%

Member 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.**

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**Instructions to Member:** Please complete and sign your portions of this form and obtain the necessary information and signature from your healthcare provider. **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 below. Then total the points, 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.**

**Note to Member:** We are 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 us at 800-627-1188 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. The information from your Health Qualification Form is strictly confidential and will not be shared with your employer. Blue Cross of Idaho will only inform your employer of your qualification status.

**Source:** Blue Cross of Idaho bases ranges on clinical guidelines available to members and providers on the Blue Cross of Idaho website at [bcidaho.com](http://bcidaho.com).

**Questions about this form?**

Contact Blue Cross of Idaho Customer Service by phone at **(208) 331-7347 or (800) 627-1188**  
or email inquiries to: **CustomerService@BCIdaho.com**

**Mail a copy of completed form to:**

Blue Cross of Idaho, Attn: Healthy Measures/HQF, P.O. Box 7408, Boise, ID 83707-1408  
or Fax Toll Free to: **800-471-4424** or Scan & Email to: [healthymeasures@bcidaho.com](mailto:healthymeasures@bcidaho.com)

**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.