PROFESSIONAL ADMINISTRATIVE NOTICE: 2017P-01-006

Date: January 1, 2017

Professional Providers—New Information and/or Reminders

The subjects covered in this Professional Administrative Notice are:

 Healthy Rewards Program – Biometric Screening Form

Healthy Rewards Program – Biometric Screening Form

☒ New Information ☐ Reminder

The following information pertains to Primary Care Physicians (PCP’s) only:

Beginning January 1, 2017, Capital BlueCross is implementing a new Healthy Rewards program designed to enhance the health and well-being of our members. The goal of the program is to give members a better picture of their overall health, develop healthy objectives, and help avoid chronic diseases. As a valued member of our provider community we wanted to make you aware of this exciting new program and some of its requirements.

As part of this program, members of some groups are being encouraged to participate in a biometric screening at their employer or by visiting their physician. If an individual chooses to obtain a screening through their doctor, they will be required to have the attached physician screening completed and submitted to earn their incentive. The patient is then responsible for submitting this form, not the provider.

As an integral part of your patients' care, we are asking for your cooperation in providing results and signing off on these forms.

Attachments

Instructions for Completing your Provider/Care Guide Screening Form

Questions

For questions regarding the information in this Administrative Notice, please contact your Provider Relations Consultant.
INSTRUCTIONS FOR COMPLETING YOUR PROVIDER/CARE GUIDE SCREENING FORM

Results of your health screening must be received by the deadline noted on your screening form to earn the health screening reward. Capital BlueCross is committed to ensuring your privacy is protected during the screening process.

Please complete the steps below to ensure the results of your health screening are received by the deadline.

1. **Make an appointment now with your health care provider or a care guide at a Capital Blue health and wellness store.**
   - **Provider screening:**
     - Ask your provider to complete the Provider/Care Guide Screening Form.
     - You may be screened by a doctor (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.) To find an in-network doctor to perform your screening, visit capbluecross.com and click Find a Doctor.
     - Your provider may require you to schedule a physical.*
     - If you recently had a preventive screening, you can ask your provider to complete the form without having an office visit. The results of a screening conducted after January 1, 2017 may be used to fulfill the Healthy Rewards requirement.
   - **Capital Blue Store screening:**
     - Call 855.505.2583 to schedule an appointment with a care guide at the Capital Blue store in Enola or Saucon Valley.
     - The care guide will perform the health screening and complete your form.

2. **Remember to:**
   - Fast 12 hours prior to your health screening appointment and drink plenty of water.
   - Take these instructions and your screening form to your health screening appointment.

3. **Return the Provider/Care Guide Screening Form**
   - The form must be completed, signed by you and the provider or care guide, submitted, and received by Healthy Rewards by December 31, 2017.
   - If your health screening is done at a Capital Blue store, the care guide will submit the form to Healthy Rewards for you.

Your results and applicable reward will be posted to the Healthy Rewards web portal. You will receive a notification when your form has been received and when your account has been updated. You may dispute the accuracy of your results or request alternative ways to achieve the same reward if a medical issue or disability prevents you from participating. Please call Customer Service to file an appeal or learn about alternatives.

You are responsible for submitting this completed form to Healthy Rewards by the due date. **Return this form to Healthy Rewards using one of the below options. Do not return this form to your employer.**

**Upload your form via phone or computer:** Log in to your secure member account at capbluecross.com and select the Healthy Rewards tab.

**Scan and email your form to:** healthyrewards@bravowell.com

**Fax:** 855.381.2937

**Mail:** Healthy Rewards
One International Place
20445 Emerald Parkway Dr. SW Suite 400
Cleveland, OH 44135

**Questions?** Call Customer Service: 855.208.1763

*Refer to your certificate of coverage or [capbluecross.com/preventive](http://capbluecross.com/preventive) for preventive benefits covered at no additional cost to you.
### PROVIDER/CARE GUIDE SCREENING FORM

**PATIENT INFORMATION:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>FirstName</th>
<th>DOB</th>
<th>Eligibility ID</th>
<th>AcctNbr</th>
<th>Gender</th>
</tr>
</thead>
</table>

**FOR PROVIDER/CARE GUIDE USE ONLY:** VALUES IN ALL FIELDS ARE REQUIRED FOR YOUR PATIENT TO RECEIVE THE REWARD

<table>
<thead>
<tr>
<th>Waist Measurement</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/4 in</td>
<td>1/2 in</td>
<td>3/4 in</td>
</tr>
<tr>
<td>Ft</td>
<td>in</td>
<td>1/4 in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Total Cholesterol</th>
<th>Triglycerides</th>
<th>HDL Cholesterol</th>
<th>LDL Cholesterol</th>
<th>Fasting Blood Sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastolic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CARE GUIDE/PROVIDER SIGNATURE**

Once the form is complete and signed, please return to the patient for submission.

**Provider/Care Guide Signature:**

**Exam Date:**

**Printed Name:**

**License #:**

**Phone #:**

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### FOR MEMBER USE ONLY: TOBACCO USE CONFIRMATION

- Yes
- No

**Have you used tobacco/nicotine products or substitutes within the past 90 days?**

Tobacco/nicotine products and substitutes include but not limited to: cigarettes, electronic cigarettes, cigars, pipe smoking, snuff, chewing tobacco, nicotine patch, gum, lozenge, and other supplements.

**MEMBER SIGNATURE AND CONSENT TO PROCESS**

I hereby certify that the information included in this form is accurate to the best of my knowledge and I authorize this data to be provided to Bravo Wellness, LLC for the purpose of administering my employer’s wellness program.

I understand that any participation in this Program is voluntary and that enrollment in or eligibility for health plan benefits is not conditioned upon providing this authorization except to the extent necessary for underwriting or risk rating determinations that may be used to reduce or increase health plan benefits or payroll contributions. By participating in the Program and screening events, I hereby accept all risk to my health that may result from such participation except in the case of gross negligence and I hereby release and agree to hold harmless my employer, my employer’s insurance agent, my employer’s selected vendors, Bravo/ISS, its affiliates including any screening company, or any independent laboratory used, and their respective officers, directors, employees, agents, successors and assigns from any and all liability to myself, my personal representatives, estate, heirs, next of kin and assigns, from any and all claims and causes of action for all illness or injury to my person resulting from my participation in the Program and the screening events.

**Member Signature:**

**Printed Name:**

Upon obtaining the provider or care guide signature, please sign and return this form to Bravo Wellness, LLC for confidential processing. The validity of this signature may be verified for authenticity. Falsification of information will be subject to disciplinary actions consistent with employee guidelines up to and including employment termination. If you have any questions, please speak with your Human Resources representative.

You are responsible for submitting this completed form to Healthy Rewards by the above due date.

Return this form to Healthy Rewards using one of the below options. Do not return this form to your employer.

Log in to your secure member account at [capbluecross.com](http://capbluecross.com) and select the Healthy Rewards tab to upload your form via phone or computer.

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- **Health Screening** is a preventive service; no cost share applies.
- **Height:** Perform the height measurement using a sliding height measuring stick. Have the patient remove their shoes and record to the nearest ¼ inch. Self-reported heights are not acceptable.
- **Weight:** Perform a weight measurement using a professional grade scale with a maximum capacity of 400 pounds. Have the patient remove their shoes and record. Do not make any adjustments for clothes and empty pockets.
- **Blood Pressure:** Perform using a standard sphygmomanometer, cuff size as appropriate. If the patient’s blood pressure is above 120/80, please take the blood pressure in the opposite arm. Please record the better of the two readings.
- **Waist:** Use a soft tape measure and place the tape measure at the navel.
- **Laboratory Testing:** Include full lipid profile and glucose with a blood test.

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**PREVIOUS SCREENING RESULTS ACCEPTED IF COLLECTED AFTER:** 01/01/2017

**FORM DUE DATE:** 12/31/2017

This form is uniquely coded with your personal information; sharing of this form is not authorized.