Keystone
HEALTH PLAN® CENTRAL
A Capital BlueCross Company

	For Office Use Only		
PCP Name:		*Date:*	
PCP Facets ID Number:		*P/R Rep:*	
PCP/Group Affiliation:		*Effective Date:*	

FAMILY PRACTICE/INTERNAL MEDICINE — FULL SERVICE BONUS CALCULATION (FSBC) — BREADTH OF SERVICE

In order to update information which Keystone Health Plan Central (KHP Central) has on record regarding the breadth of service which your office provides our members, we need to have you complete the following brief questionnaire. This information is necessary for KHP Central to accurately represent your practice to our members and to adequately compensate you for the services you provide. It is imperative that we have accurate and current information on our primary care physician providers, so please take the time to answer the following questions, sign the questionnaire after reviewing it for accuracy and return it in the enclosed postage-paid envelope.

		YES	NO
1.	Does **your office** draw blood on KHP Central members requiring laboratory tests most or all of the time such tests are necessary?	☐	☐
2	Do your KHP Central members who sustain lacerations, which require suturing, usually have these wounds repaired **in your office**?	☐	☐
3.	Does **your office** provide gynecological care to female patients (pap smears, treatment of vaginitis) on a routine basis?	☐	☐
4.	Do the **physicians in your practice** provide inpatient medical care (other than to newborns) for most non-surgical KHP Central patients who require hospitalization?	☐	☐
5.	Does **your practice** offer at least three hours of available appointment time on weekends (Saturday and/or Sunday)?	☐	☐
6.	Answer only one of the following:		
	a. Solo practice: Does **your office** offer at least three hours of available evening appointments (after 5:00 p.m.) per week?	☐	☐
	b. Group practice: Does **your office** offer at least six hours of available evening appointments (after 5:00 p.m.) per week?	☐	☐
7.	Does **your practice** perform spirometry (not just peak expiratory flow) when indicated, **in your office**?	☐	☐
8.	Does **your practice** perform audiometry, when indicated, **in your office**?	☐	☐
9.	Does **your practice** perform excision of skin lesions, when indicated, **in your office**?	☐	☐
10.	Does **your practice** perform colposcopy or flexible sigmoidoscopy, when indicated, **in your office**?	☐	☐

Is **your practice** currently open to new patients? **YES** ☐ **NO** ☐

If the answer is "No", please check the appropriate box(es) below:

- ☐ Accept existing patients only.
- ☐ Accept dependents of existing patients only.
- ☐ Existing patients and newborns only.
- ☐ Existing patients only. No newborns.
- ☐ Accept limited number of members.
- ☐ Closed.

If your practice has age restrictions, please check ONE appropriate box: *(Please do not hand write any other option.)*

- ☐ Practice limited to ages 2 and older.
- ☐ Practice limited to ages 5 years and older.
- ☐ Practice limited to ages 8 and older.
- ☐ Practice limited to ages 12 years and older.
- ☐ Practice limited to ages newborn to age 13.
- ☐ Practice limited to ages 14 and older.
- ☐ Practice limited to ages 16 and older.
- ☐ Practice limited to newborns through age 18.
- ☐ Practice limited to ages 18 and older.
- ☐ Practice limited to newborns through age 21.

I attest that I have read and reviewed the questions and answers above and I agree that the information supplied is correct.

______________________________ Signature of Physician Completing Questionnaire

______________________________ Date

______________________________ Please Print or Type Name of Signing Physician

Last Revised 01/07/2008

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