

# HealthbyChoice Motivations<sup>SM</sup>

## Qualification Form



All fields are required unless noted.

**Members:** If you have diabetes, your HbA1C test is not considered preventive. Your deductible will apply, along with applicable office visit copays and coinsurance for this test.

**Provider:** Please complete this form and submit it to Priority Health. The form may be submitted at any time during the member's plan year. For online submission, go to [priorityhealth.com](http://priorityhealth.com).

Fax number for submission: 616 975-8860. For instructions please see the provider manual.

### Section 1: Member information

Last name		First name	
Last four digits of Social Security number X X X - X X - _ _ _ _		Birth date / /	Contract ID number

The information below can also be completed online in the Provider Center by going to the **HealthbyChoice forms section**.

### Section 2: Health indicators (to be completed by provider)

Criteria	Date	Measured within	Result	Does patient have a condition that prevents him/her from meeting the criteria? <sup>2</sup>
<b>Tobacco user<sup>1</sup></b> Non-tobacco user	/ /	Last 6 months	<input type="checkbox"/> Tobacco user <input type="checkbox"/> Non-tobacco user	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>BMI</b> < 30	/ /	Last 6 months	Height = ___ ft. ___ in. Weight = ___ lbs. BMI = ___ . ___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exception if pregnant
<b>Blood pressure</b> < 140/90	/ /	Last 6 months	BP = ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cholesterol</b> LDL < 160 82465 <sup>4</sup>	/ /	Last 5 years, depending on patient's health <sup>3</sup>	Fasting LDL = _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Blood sugar</b>  <i>Without diabetes</i> < 126 (fasting), 82947 <sup>4</sup> , or < 180 (non-fasting), 82948 <sup>4</sup>  <i>With diabetes</i> HbA1C < 8%, 83036 <sup>4</sup>	/ /	Last 5 years, depending on patient's health <sup>3</sup>	FBS = _____ or Non-FBS = _____  HbA1C = ___ . ___	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Section 3: Physician approval

I certify that the information is complete and accurate. I agree to keep a copy of this form in the patient's chart for follow-up and Priority Health audit.

Tax ID (required for payment)		Provider group name (as it appears on your check)	
Billing physician name			NPI number
Physician signature			Date

<sup>1</sup> Any type of tobacco use    <sup>2</sup> If yes, this member will be placed in Case Management services.    <sup>3</sup> National guidelines recommend cholesterol testing for healthy individuals every 5 years and blood sugar testing when the patient's health calls for it. You can decide whether your patient's test results on file reflect their current health or if they should be retested.  
<sup>4</sup> Suggested CPT billing code