FOR GROUPS WITH A JULY 1, 2016 EFFECTIVE DATE OR LATER

PriorityHealth

HealthbyChoice® Incentives Qualification form

All fields are required unless noted.

Members: Complete section 1. Please have your provider complete this form and submit it to Priority Health. If we do not receive the form, you will be moved from the Choice to the Standard level. Labs completed may be subject to deductible, coinsurance or copayment. If you have diabetes, your HbA1c test is not considered preventive and your deductible will apply, along with applicable office visit copayment and coinsurance for this test.

Provider: Complete sections 2, 3 and 4 of this form and submit information to Priority Health. Go to *priorityhealth.com/provider/forms* and scroll to the **Health**byChoice section. Network providers: submit results online for a $30 reimbursement per form by clicking the online qualification tool. Non-participating providers may fax forms to 616.975.8860.

1 Member information *(completed by member)*

Last name	First name	Middle initial

Last four digits of social security number	Birth date	Contract ID number	Effective date
XXX - XX -	/ /		/ /

I certify that the information I am providing to my provider is complete and accurate. I also agree to a follow-up plan with my provider, if applicable. I authorize my provider to release this information to Priority Health. All information will be handled confidentially.

Signature	Date
	/ /

2 Incentives health criteria *(completed by provider)*

Qualifying results may be used from up to six months prior to the member's effective date.

HEALTH INDICATOR	RESULT	CRITERIA MET	DATE
Tobacco user (including electronic cigarettes) Must be tobacco-free	☐ Tobacco user ☐ Non-tobacco user	☐ Yes ☐ No	Test not required
Body mass index (BMI)[1] <30 **or waist circumference** <41" (male); <35" (female)	BMI = or waist cir. =	☐ Yes ☐ No	/ /
Blood pressure <140/90 or <150/90 for those 60 years of age or older	BP = /	☐ Yes ☐ No	/ /

Proceed to Section 3 if any of the three health indicators above are marked "No" for criteria met.
Proceed to Section 4 if all three health indicators are marked as "Yes" for criteria met.

3 Additional requirements *(complete if indicators in Section 2 not met)*

Qualifying results may be used from up to six months prior to the member's effective date. Member must complete testing within 90 days.

HEALTH INDICATOR	RESULT	DATE OF TEST
Fasting cholesterol test (82465)[2]	☐ Test completed	/ /
Fasting blood sugar (82947)[2]	☐ Test completed	/ /
Provider follow-up plan	Member has agreed to comply with a follow-up plan in all areas where the health indicator criteria were not met.	☐ Yes ☐ No

4 Physician approval

Tax ID	Provider group (as it appears on your check)	Phone number
		( )

Billing physician name	NPI number (if available)

I acknowledge that this member has met the requirements listed above for the **Health**byChoice Incentives plan.
I agree to keep a copy of this form in the patient's chart for follow-up and Priority Health audit.

Physician signature	Date
	/ /

[1]A member who is pregnant can meet the BMI or waist circumference criteria at the provider's discretion. Write "Pregnant" in the "RESULT" box and check "YES" for CRITERIA MET. [2]Suggested CPT billing code.