Health and Wellness Evaluation Form

CareFirst® Family of health care plans

Section I: Participant Information – to be completed by Participant annually

Last Name	First Name	MI

Date of Birth	Gender	Phone Number
____/____/______ mm dd yyyy	Male Female	_____ - _____ - _____

If insured by CareFirst BlueCross BlueShield:	*If not insured by CareFirst BlueCross BlueShield:*
Group Number	**Employer Name**
Member ID Number	**Alternate ID Number**

Please select one:

Initial Screening

Rescreening (*For Participants who purchase insurance through an employer only)*

Check measures to be rescreened: ☐ Weight ☐ Flu Vaccine ☐ Tobacco ☐ Blood Pressure ☐ Blood Glucose ☐ Cholesterol

Section II: Provider Information – to be completed by Provider

Provider Name	
Provider ID Number	**Provider Phone Number**

Section III: Health Measures – to be completed by Provider

Please provide measurements for each category below, or if it is not medically advisable for your patient to be measured on a specific health factor based on clinical circumstances, please indicate "Waiver."

Alternative Standards: *Patients who receive insurance through their employer may be eligible for an incentive based on their results. Please see directions below for setting alternative standards, if applicable.*

During the Initial Screening:

- If your patient doesn't meet the recommended goal, you can determine an acceptable alternative. Check "Alternative Standard Set."
- If you check "Alternative Standard Set," please develop an alternate goal for the patient to meet, including a plan to improve and maintain his/her health.

During the Rescreening:

- If you recommended an "Alternative Standard Set" during the initial screening, please check "Alternative Standard Met" if the patient's goal was reached at the rescreening and fill out the new measurements where indicated.

1. Weight (required for ages 2 and older)

☐ **Waiver provided by PCP**

Date measured: _____/________ (mm yyyy) Adult BMI: ______________ Child BMI: ________percentile

Adult Height: _________in Adult Weight: _________lbs Adult Waist Measurement: _________in

GOAL: Adult Body Mass Index (BMI) is between 19 and less than 30 • Child BMI is in the 5th to 85th percentile depending on age and gender

If applicable: ☐ Alternative Standard **Set** at initial screening ☐ Alternative Standard **Met** at rescreening

(continued)

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Section III: Health Measures (continued)

2. Flu Vaccine (required for ages 2 and older) ☐ **Waiver provided by PCP**

Up-to-date on Flu Vaccine? ☐ Yes ☐ No

Date of last Vaccine: ____/______ (mm yyyy)

GOAL: Within last 18 months

3. Tobacco Use (required for ages 18 and older) ☐ **Waiver provided by PCP**

Date measured: ____/______ (mm yyyy)

☐ Non-Smoker ☐ Smoker

GOAL: Non-smoker (never smoked or quit for more than 30 days)

If applicable: ☐ Alternative Standard **Set** at initial screening ☐ Alternative Standard **Met** at rescreening

4. Blood Pressure (required for ages 18 and older) ☐ **Waiver provided by PCP**

Date measured: ____/______ (mm yyyy)

BP Reading: ________/__________

GOAL: Less than 140/90 (ages 18-59); Less than 150/90 (ages 60+)

If applicable: ☐ Alternative Standard **Set** at initial screening ☐ Alternative Standard **Met** at rescreening

5. Blood Glucose (required for ages 18 and older) ☐ **Waiver provided by PCP**

Date measured: ____/______ (mm yyyy)

Fasting* ☐ Yes ☐ No

Blood Glucose Reading: ________________Fasting*

GOAL: Fasting Blood Glucose is less than 100

If applicable: ☐ Alternative Standard **Set** at initial screening ☐ Alternative Standard **Met** at rescreening

6. Cholesterol (for ages 18 and older) ☐ **Waiver provided by PCP**

Date measured: ____/______ (mm yyyy)

Fasting* ☐ Yes ☐ No

Total Cholesterol: ______________

LDL:___________ HDL:__________ Triglycerides:___________

GOAL: Collect fasting baseline data

If applicable: ☐ Alternative Standard **Set** at initial screening ☐ Alternative Standard **Met** at rescreening

**This means you have not had anything to eat or drink other than water or coffee/tea without sugar or cream in the last 9-12 hours.*

Section IV: Screening Signatures

I hereby certify that the information provided on this form is true and accurate to the best of my personal knowledge and understand that any material misrepresentation(s) will disqualify my dependents, if applicable, and me from receiving any incentive if incentives are included in my program.

Participant Signature **Date**	**Provider Signature** **Date**

Submission Instructions for Participant:

Submit the results of this completed form by logging into *My Account* at **www.carefirst.com**. Please check your enrollment materials for specific submission deadline requirements.