

CARE PLAN FORM



This form can be submitted to HealthPlus in the following ways:

- Fax a copy of this form to: (810) 496-8470
- Email a copy to wellness@healthplus.org.
- Mail a copy to: Health & Lifestyle Dept., HealthPlus of Michigan, 2050 S. Linden Road, Flint, MI 48532

Questions? Call 1-866-810-4540.

This form must be completed by the member's primary medical provider and submitted to HealthPlus by Sept. 20, 2012. Failure to submit this form by the due date will result in the member receiving non-preferred rates on their medical contributions.*

SECTION 1 MEMBER INFORMATION (to be completed by member)

Member Name (Last) (First) DOB (MM-DD-YYYY)

Member's Home Email Address HealthPlus Subscriber Number

The information I have supplied to my primary medical provider is complete and accurate. If applicable, I agree to follow my primary medical provider's recommended care plan.

Home Phone Number

Member signature: _____ Date (MM-DD-YYYY)

SECTION 2 YEAR 1—HEALTH INDICATORS (to be completed by primary medical provider)

Health data 12 months prior to today's date may be used.

Date of Visit (MM-DD-YYYY)

TOBACCO (Includes all forms of tobacco)	BODY MASS INDEX	BLOOD PRESSURE
<p>Member Status (please check one)</p> <p><input type="radio"/> A. Nonsmoker/nonuser</p> <p><input type="radio"/> B. Commits to follow provider's care plan</p> <p><input type="radio"/> Refer to HealthPlus Tobacco Cessation Coaching Program</p> <p><input type="radio"/> Prescribe medication</p> <p><input type="radio"/> Prescribe nicotine replacement therapy</p> <p><input type="radio"/> Other: _____</p>	<p>Member Status (please check one)</p> <p>BMI: <input type="text"/></p> <p><input type="radio"/> A. BMI ≤30 (except if pregnant)</p> <p><input type="radio"/> B. Commits to follow provider's care plan</p> <p><input type="radio"/> Refer to HealthPlus Weight Management Coaching Program</p> <p><input type="radio"/> Recommend Weight Watchers or Jenny Craig</p> <p><input type="radio"/> Recommend fitness/exercise program</p> <p><input type="radio"/> Other: _____</p>	<p><input type="radio"/> Newly diagnosed hypertension</p> <p>BP: <input type="text"/></p> <p>Member Status (please check one)</p> <p><input type="radio"/> A. Blood pressure <140/90 (<130/80 if member has diabetes)</p> <p><input type="radio"/> B. Commits to follow provider's care plan</p> <p><input type="radio"/> Refer to fitness/exercise program</p> <p><input type="radio"/> Recommend healthy eating program</p> <p><input type="radio"/> Prescribed medication</p> <p><input type="radio"/> Other: _____</p>

SECTION 3 YEAR 2/3 — PROGRESS (Only to be completed in 2013 or later)

Date of Visit (MM-DD-YYYY)

TOBACCO (Includes all forms of tobacco)	BODY MASS INDEX	BLOOD PRESSURE
<p>Member Status (please check one)</p> <p><input type="radio"/> A. Nonsmoker/nonuser</p> <p><input type="radio"/> B. Has made progress since last visit</p> <p><input type="radio"/> C. Has not made progress/refuses**</p>	<p>Member Status (please check one)</p> <p>BMI: <input type="text"/></p> <p><input type="radio"/> A. BMI ≤30 (except if pregnant)</p> <p><input type="radio"/> B. Has made progress since last visit</p> <p><input type="radio"/> C. Has not made progress/refuses**</p>	<p>Member Status (please check one)</p> <p>BP: <input type="text"/></p> <p><input type="radio"/> A. Blood pressure <140/90 (<130/80 if member has diabetes)</p> <p><input type="radio"/> B. Has made progress since last visit</p> <p><input type="radio"/> C. Has not made progress/refuses**</p>

**Please note: If any "Cs" are marked, member will not be eligible for preferred rates on medical contributions.

SECTION 4 PLEASE SIGN THE FORM, PROVIDE A COPY TO THE MEMBER, AND FAX THIS FORM TO HEALTHPLUS AT (810) 496-8470.

Primary Medical Provider's Address — Line 1 (please print):

Primary Medical Provider's Address — City (please print): State Zip Provider's Phone Number

Primary Medical Provider's Name (Last) (First) NPI#

Signature: _____ Date (MM-DD-YYYY)

Please mail/fax a copy of this completed form to HealthPlus, give one copy to the member, and keep one copy for your records. Thank you. For billing purposes, use Billing code 99401.

* An annual HealthQuest Profile is also required for Preferred rates.

For optimum accuracy, characters should be written block style without touching the sides using a black or blue pen. All letters should be capitalized.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8 9