Blue Cross Blue Shield of Rhode Island

BlueCHiP For Healthy Options

Primary Care Physician Checklist *Adolescents (12 to 17)*

IMPORTANT: To maintain the BlueCHiP for Healthy Options Advantage-level benefits, this form must be completed by the primary care physician (PCP) of each adolescent member (aged 12 to 17 at the time of enrollment). The subscriber or member must mail this form to the following address **no later than eight months (240 days) after enrollment.**

Small Group Underwriting - 00132
Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

If we do not receive a PCP Checklist for each adult and applicable adolescent family member within 240 days of enrollment, **the entire family will be switched to Basic level benefits.** ***Questions? Please call us at (401) 274-3500 or 1-800-564-0888 (TDD 1-888-252-5051).***

Member Name: _____

Address: _____

_____

Member Identification Number: _____

Date of Birth: _____

Date of Examination: _____

Body Mass Index

1. Body Mass Index (BMI) Calculation:

a. Weight: _____ **b.** Height: _____ **c.** BMI:_____

2. The member's BMI is above his/her recommended BMI level:

Yes ❑ **No ❑**

3. If the member's BMI is above the recommended level, have you discussed a weight-loss program or goal with the member and the member's parent or guardian:

Yes ❑ **No ❑**

(Please leave blank if member's BMI is within the recommended level.)

4. Briefly describe the program or goal:_____

_____

_____

5. Additional Comments: _____

_____

_____

Smoking

1. Is the member a smoker (smoked within the last six months):

Yes ❑ **No ❑**

2. If the member is a smoker, have you discussed a smoking cessation program or goal with the member and the member's parent or guardian:

Yes ❑ **No ❑**

(Please leave blank if the member is not a smoker.)

3. Briefly describe the program or goal: _____

_____

_____

_____

4. Additional Comments: _____

_____

_____

_____

Physician Signature *(Required)*

The above information is complete and accurate to the best of my knowledge.

Physician Name (printed):

_____

Physician Signature:

_____

Date _____

Parent or Guardian's Signature *(Required)*

I have reviewed and discussed the above information with my adolescent's physician, and I agree to follow his or her recommendations. I understand that submission of this PCP Checklist is required to continue in Advantage-level benefits under my HEALTHpact plan.

Parent/Guardian Signature:

_____

Date _____

a HEALTHpact plan

BlueCHiP for Healthy Options complies with the Rhode Island Office of the Health Insurance Commissioner's (OHIC) requirements for a HEALTHpact plan. HEALTHpact plans are designed to assist small employers in offering health coverage that encourages members to make healthy lifestyle choices by meeting certain Wellness Participation Requirements.

You can download a blank copy of this PCP Checklist from BCBSRI.com.

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