

<p>IMPORTANT: To maintain the BlueCHIP for Healthy Options Advantage level benefits, this form must be completed by the primary care physician (PCP) of each adult (aged 18 and older at the time of enrollment) member. The subscriber or member must mail this form to the following address no later than eight months (240 days) after enrollment.</p>	<p>Small Group Underwriting - 00132 Blue Cross & Blue Shield of Rhode Island 500 Exchange Street Providence, RI 02903-2699</p>
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If we do not receive a PCP Checklist for each 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: _____ Member Identification Number: _____
 Address: _____ Date of Birth: _____
 _____ Date of Examination: _____

Body Mass Index

- Body Mass Index (BMI) Calculation:
 a. Weight: _____ b. Height: _____ c. BMI: _____
- The member's BMI is above his/her recommended BMI level:
 Yes No
- 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.)
- Briefly describe the program or goal: _____

- Additional Comments: _____

Smoking

- Is the member a smoker (smoked within the last six months):
 Yes No
- 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.)
- Briefly describe the program or goal: _____

- Additional Comments: _____

Physician Signature (Required)

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

Physician Name (printed): _____
Physician Signature: _____
Date _____

Member Signature (Required)

I have reviewed and discussed the above information with my 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. I further understand that I am required to submit a Self-Reporting Form, documenting my compliance with my physician's recommendations.

Member 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.



500 Exchange Street • Providence, RI 02903-2699

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