

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 (aged 12 to 17 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.**

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 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

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 _____



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.



www.BCBSRI.com

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