Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

BLUE CROSS BLUE SHIELD OF MICHIGAN

PHYSICIAN VERIFICATION FORM

Provider Instructions: Please complete and sign this form. FAX the completed form to Blue Cross Blue Shield of Michigan Engagement Center 1-877-885-2596. Do not forward the form through Provider Secured Services.

PATIENT INFORMATION

Patient's last name:	Patient's first name:	Age:	Gender: ❑ M ❑ F	Birth date:
Street address:			Home phone no.: ( )	
City:	State:	ZIP Code:	Contract ID/Enrollee Number:	
Group Number:	Employer:			

MEDICAL WAIVER

If your patient is unable to meet their clinical criteria or physical activity requirements, check the appropriate value(s) below. By signing this form you verify that it is medically inadvisable or unreasonable for the patient to achieve the criteria or participate in the physical activity requirement.

❑ A1c
❑ BMI
❑ Blood pressure
❑ Cholesterol
❑ Fasting blood sugar
❑ Non-tobacco user
❑ Walk a required number of daily steps
❑ Waist circumference

Medical Waiver Reason (check the appropriate reason):

❑ Patient in hospice (waive all requirements)
❑ Patient is pregnant (waive BMI, waist circumference, blood pressure, cholesterol, and blood sugar only)
❑ Patient has muscular build (waive BMI only)
❑ Other (provide reason in the space below):

Reason:

HEALTH MEASURE ACHIEVED

When the Qualification Form was completed or a worksite screening conducted, my patient did not meet their health measure value. They now meet their requirement(s) as documented below:

❑ BMI value _____
❑ Blood pressure value ____ /____
❑ Blood sugar (FBS) value _____
❑ Blood sugar (A1c) value _____%
❑ Cholesterol value _____
❑ Non-tobacco user (based on a new continine test) _____ ng/mL
❑ Waist circumference value _____

Date of evaluation: _____

PHYSICIAN INFORMATION

Physician last name:	Physician first name:	NPI:
Physician signature:	Date:	Phone number: ( )