PacificSource HEALTH PLANS

Health Qualification Form

Today's Date _____

1. Member Information (to be completed by member)

Name _____ Member ID Number _____ Birth Date _____

Email _____ Employer or Group Name PCSD Group Number G0032790

Phone _____ ☐ Work ☐ Cell ☐ Home ☐ Employee ☐ Spouse

2. Patient Evaluation (to be completed by the provider)

Screening Date _____

Health Measure	Healthy	Elevated Risk	High Risk
Blood Pressure: ____/____mmHg	<120/80 mmHg	Systolic 120-129 and diastolic <80 mmHg (pre-hypertension)	Stage 1: systolic 130-139 or diastolic 80-89 mmHg Stage 2: systolic ≥ 140 or diastolic > or equal to 90 mmHg
	Consult with your doctor/provider regarding your blood pressure if you have diabetes, a kidney condition, other chronic conditions, or if you are currently taking blood pressure medications.		
Lipid Panel: HDL _____ mg/dL LDL _____ mg/dL TChol _____ mg/dL Triglycerides _____ mg/dL	HDL: >60mg/dL LDL: <70-100mg/dL depending on health of heart TChol: <200 mg/dL Triglycerides: <150mg/dL Chol: HDL ratio: <5.0	HDL: 40-59mg/dL LDL: 100-159mg/dL TChol: 200-239 mg/dL Triglycerides: >150-199mg/dL Chol: HDL ratio: >5.0	HDL: <40 mg/dL for men <50mg/dL for women LDL: ≥160mg/dL TChol: >239mg/dL Triglycerides: >200mg/dL Chol: HDL ratio: >5.0
Blood Glucose/A1C lab: _____mmHg _____ %	Fasting: ≤99 mg/dL A1C ≤5.6%	Pre-diabetes Fasting: 100-125mg/dL A1C 5.7-6.4%	Diabetes Fasting: ≥126mg/dL A1C ≥6.5%
A1C if already diagnosed with diabetes: %/Target _____%	Generally ≤7% (ADA), but this varies by person; work with your provider to determine target goals.		
BMI: Weight_____ lbs. BMI _____ Height _____ in.	18.5-24.9 kg/m²	Overweight: ≥25-29.9 kg/m² Asian-Americans: ≥23-26.9 kg/m²	Obese: ≥30 kg/m² Asian-Americans: ≥27 kg/m²
Tobacco Usage: ☐ Yes ☐ No	Tobacco-free		Tobacco user

Provider Recommendation: If any category above is elevated risk or high risk, please refer patient to appropriate programs, services, or recommendations: _____

Recommended Follow-up: ☐ 3 months ☐ 6 months ☐ 1 year ☐ As needed

Continued on reverse >

3. Provider and Member Verification

By signing below, both parties agree that the above information is complete and accurate. All medical information on this form is confidential. Your results will not be shared with your employer.

Provider Name _____ Member Name _____

Provider Signature _____ Member Signature _____

Authorization for Disclosure of Protected Health Information between PacificSource Health Plans and Wellness 2000, Inc., a third-party administrator

I voluntarily authorize PacificSource Health Plans and its business associates to use, disclose, and release to each other and exchange the protected health information (PHI) captured on this form for the purpose of participation in my employer-sponsored wellness program. The results gathered from this testing will NOT be shared with my employer.

I also acknowledge that my employer may be provided essential participation information (e.g., name, date of birth, member ID, and completion status).

Next Steps

Return this form to the address or fax number listed below to protect your privacy. Keep a copy for your records.
PacificSource Health Plans | Attn: Wellness Consultant | 408 E. Parkcenter Blvd. Suite 100 | Boise, ID 83706
To fax this form: Attn: Wellness Consultant **(208) 801-4421** or toll-free at **877-398-5245**

For questions about your health plan, please contact customer service at **(208) 333-1596.**