



# Wellness Exam - Female

Employee, Spouse, Child Age 19 and Over, and Retiree under Age 65

**Who completes this Exam:** ALL Members regardless of age in order to qualify for the ULTIMATE, BEST or BETTER health plan level.

**Submit Form To:** Your Insurance Coordinator

## ▼ MEMBER SECTION ▼

Qualifying Events are subject to audit which may result in a plan level change.

<b>Participant Name:</b>	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> Retiree	<b>Date of Birth:</b>	<b>Age on 1/1/20:</b>
<b>Email Address:</b>	<b>Phone #:</b>		
<b>Employee's Name:</b>	<b>Employee ID#:</b>		

**A "NO" RESPONSE ON 1-7 BELOW WILL RESULT IN BEING PLACED IN THE BASIC OR BETTER PLAN LEVEL!**

## ▼ PHYSICIAN SECTION ▼

The Wellness Exam and screenings listed below require **NO CO-PAY** by the YourChoice member. For claim accuracy, be sure the correct diagnosis and procedural code is utilized. If a medical problem is identified requiring management, the ICD-10 code should be used as a secondary diagnosis, and a follow up visit with member co-pay is required.

**EXAMS & SCREENINGS (According to CDC, ACG, or USPSTF).** Complete according to the age guidelines provided, based on age as of 1/1/20.

**The patient has completed the following exams/screenings:**

1	Blueprint for Wellness Labs between 9/1/19 – <b>6/30/20</b> (note earlier date)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Preventive Physical Exam with Skin Screening between 9/1/19 – 8/31/20	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Clinical Breast Exam between 9/1/19 – 8/31/20	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Pelvic Exam between 9/1/19 – 8/31/20	<input type="checkbox"/> Yes <input type="checkbox"/> Not recommended
5	Pap Smear in past 3 years (age 21+ as of 1/1/20)	<input type="checkbox"/> Yes <input type="checkbox"/> Not recommended
6	Mammogram in past 2 years (age 40-49) or annually (age 50+) between 9/1/19 – 8/31/20	<input type="checkbox"/> Yes <input type="checkbox"/> No (leave blank if under age 40 as of 1/1/20)
7	Colorectal Screening (age 50 or older as of 1/1/20)	<input type="checkbox"/> Yes <input type="checkbox"/> No (leave blank if under age 50 as of 1/1/20). <b>Please indicate which screening was completed:</b> <input type="checkbox"/> Colonoscopy in past 10 years <input type="checkbox"/> Or, Cologuard (FIT-DNA stool test) in past 3 years <input type="checkbox"/> Or, CT Colonography in past 5 years (precertification required)
8	Patient has Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Results of Cotinine Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
10	Patient is encouraged to follow up with the supportive onsite health and wellness services offered by Manatee County YourChoice Health Plan to address existing modifiable health risks. <i>Services recommended:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**I attest that this patient has completed the screenings as indicated above.**

**(Required) Physician Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**(Optional) Additional Physician Name, if applicable** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_