Independent Health's

Prime Access℠ Patient Engagement Form

A Patient Engagement Form is to be used for the **subscriber** enrolled within the Prime Access plan.

A separate Patient Engagement Form must also be used for the subscriber's spouse or domestic partner, if applicable (if covered as a dependent under Prime Access and submitted to Independent Health, as described below).

This form must be completed by you and your provider and submitted by the subscriber (and a separate form by the subscriber's covered spouse or domestic partner, if applicable) to Independent Health **within three months of the group's effective date or renewal date of coverage.** The successful completion and submission of this form to Independent Health will determine eligibility to remain in the **Enhanced Level of benefits.**

Please note: There is no member liability for this provider service.
Provider Office: You may bill one of the following codes for services rendered: G8539 – Form only. T1023 – Form and visit.

SECTION 1 MEMBER INFORMATION *to be completed by the member*

Name (Last, First, Middle Initial):	Date of Birth:
Address:	Member ID:

SECTION 2 HEALTH INDICATORS *to be completed by the provider*

Qualifying results may be used from up to six months prior to the member's effective date. Attention provider: Please do not reference the patient's genetic history to ensure compliance with GINA (Genetic Information Nondiscrimination Act of 2008).

Screening	Patient Value	Date
Cholesterol	_____Total _____LDL	
Blood Pressure	_____Systolic _____Diastolic	
Body Mass Index	____Height (in.) ____Weight (lbs.) ____BMI $BMI = \frac{(\text{weight in pounds} * 703)}{(\text{height in inches})^2}$	
Tobacco Use	☐ Do not use tobacco ☐ Use tobacco	
Treatment Plan ☐ Yes ☐ No	Please indicate any exceptions to healthy ranges per physician judgment:	

SECTION 3 PATIENT/PROVIDER ENGAGEMENT PLAN

The following Patient/Provider Engagement Plan is an opportunity for you and your provider to talk about your health. If there are opportunities for improvement, this engagement plan offers you and your provider a place to begin, as well as an opportunity to discuss and agree upon specific actions to help you achieve your personal health goals.

Patient Responsibilities	*Provider Responsibilities*
Emergent/Urgent Care Use	
• I agree to call the office prior to using urgent care and to notify my primary care physician immediately after visiting the emergency room.	• I agree to provide same-day appointments, convenience hour access and guidance on where to receive care when the office is not open.

Patient Responsibilities	*Provider Responsibilities*
Hospital Use	
• I agree to contact my primary care physician immediately upon hospital discharge to home.	• I agree to make myself available within seven days of hospital discharge when follow-up care is required.
Specialist Care	
• I will discuss specialty care with my primary care physician prior to seeing a specialist.	• I agree to recommend preferred specialists when indicated and to coordinate care with any specialist to whom I refer you.
Medication Management and Generic Use	
• I agree to consider generic use where appropriate. • I agree to speak to the pharmacist when filling new prescriptions to ensure I understand their use and the impact they may have upon other medications I take.	• I agree to discuss generic medication opportunities when they exist and to provide medication reconciliation at least once per year for medication safety.
Preventive Guidelines	
• I agree to remain current with preventive care for my age and gender.	• I agree to provide preventive care in accordance with established preventive care guidelines.
Tobacco Use (If Applicable)	
• I agree to work on a smoking cessation plan.	• I agree to provide guidance on nicotine replacement therapy and smoking cessation plans.
Care Planning	
• I agree to review options for advance care planning for myself and my loved ones. • I agree to work with my primary care physician on a care plan to improve or maintain my health.	• I agree to discuss care preferences and advance care options during annual well visits to ensure I understand your wishes. • I agree to discuss a plan to reduce health risks to improve or maintain general health.

SECTION 4 PATIENT AND PROVIDER CONFIRMATION

Patient Name:	
I certify that the information I am providing to my provider is complete and accurate. I also agree to follow any applicable treatment plan and expected behaviors that my provider and I establish. I authorize my provider to release this information to Independent Health. All information will be handled confidentially.	
Signed:	Date:
Provider Name:	
Signed:	Date:

Submit completed Patient Engagement Plan Forms to: P.O. Box 710, Attn: Membership Operations, Buffalo, NY 14221
Fax: (716) 631-4059

It is recommended that both the provider and patient keep a copy of the Patient Engagement Plan Form for your records.

For Internal Use Only. Date Received by Independent Health:

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