

MVP New Hampshire HealthFirst Wellness Verification Form



For detailed information about the New Hampshire HealthFirst Wellness Incentive and how to submit your wellness verification form, refer to the *HealthFirst Wellness Incentive Program Guide*.

For policies that cover two or more adults: the subscriber and spouse/civil union partner must complete their portion of the wellness verification form to obtain the wellness reward.

- Wellness Reward will not be granted to either the subscriber or the spouse/civil union partner until **both** adult members complete all wellness verification form requirements.
- If a partially completed form is submitted, the claim will be denied and the form and corresponding materials will be returned to the submitted member.

SUBSCRIBER INFORMATION (PLEASE PRINT):

SUBSCRIBER ID #:

MEMBER'S LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH (MM/DD/YYYY) PHONE NUMBER

ADDRESS

CITY/STATE/ZIP CODE

SPOUSE/CIVIL UNION PARTNER INFORMATION (PLEASE PRINT):

SUBSCRIBER ID #:

MEMBER'S LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH (MM/DD/YYYY) PHONE NUMBER

ADDRESS

CITY/STATE/ZIP CODE

WELLNESS MEASURE	CRITERIA FOR COMPLIANCE	SUBSCRIBER 1	SPOUSE/CIVIL UNION PARTNER
1. Relationship with a Primary Care Provider <i>MVP reserves the right to confirm this information with your Primary Care Provider.</i>	1. I pledge that I have established and continue to have a relationship with a Primary Care Provider (PCP). Name of Primary Care Provider: _____ Address of Primary Care Provider: _____ Phone # of Primary Care Provider: _____ Have been a patient since (YYYY): _____	<input type="checkbox"/> _____ _____ _____ _____	<input type="checkbox"/> _____ _____ _____ _____
2. Completion of a Personal Health Assessment	2. I pledge that I have completed the Personal Health Assessment and I am returning it with this form.	<input type="checkbox"/>	<input type="checkbox"/>
3. Smoke-Free Commitment (Check 3A or 3B)	3A. I pledge that I have been smoke-free for at least 90 consecutive days and plan to remain smoke-free in the future. 3B. I have recently completed a Smoking Cessation Program. <i>Please provide proof of completion - certificate, etc.</i>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	Name of Smoking Cessation Program: _____ Program Contact Name: _____ Program Contact Phone #: _____	_____ _____ _____	_____ _____ _____

WELLNESS MEASURE	CRITERIA FOR COMPLIANCE	SUBSCRIBER 1	SPOUSE/CIVIL UNION PARTNER
4. Body Mass Index (BMI) (Check 4A or 4B)	Screening Provider and Date <i>(Include screening results with submission)</i>	_____	_____
	BMI	_____	_____
	4A. My BMI is in the recommended range (≤ 25)	<input type="checkbox"/>	<input type="checkbox"/>
	4B. My BMI was above the recommended range (>25) and I have completed at least 2 MVP health coaching sessions.	<input type="checkbox"/>	<input type="checkbox"/>
5. Blood Pressure (Check 5A or 5B)	Screening Provider and Date <i>(Include screening results with submission)</i>	_____	_____
	mmHg	_____	_____
	5A. My Blood Pressure is in the recommended range ($\leq 140/90$ mmHg)	<input type="checkbox"/>	<input type="checkbox"/>
	5B. My Blood Pressure is above the recommended range ($>140/90$) and I have completed at least 2 MVP health coaching sessions.	<input type="checkbox"/>	<input type="checkbox"/>
6. Blood Glucose (Check 6A or 6B)	Screening Provider and Date <i>(Include screening results with submission)</i>	_____	_____
	mg/dL	_____	_____
	6A. My Blood Glucose are within acceptable levels (Fasting ≤ 100 mg/Dl or casual ≤ 125 mg/Dl).	<input type="checkbox"/>	<input type="checkbox"/>
	6B. My Blood Glucose is above acceptable levels (Fasting >100 mg/Dl or casual >125 mg/Dl) and I have completed at least 2 MVP health coaching sessions.	<input type="checkbox"/>	<input type="checkbox"/>
7. Total Cholesterol (Check 7A or 7B)	Screening Provider and Date <i>(Include screening results with submission)</i>	_____	_____
	mg/dL	_____	_____
	7A. My Total Cholesterol is within an acceptable level (≤ 240).	<input type="checkbox"/>	<input type="checkbox"/>
	7B. My Total Cholesterol is above an acceptable level (>240) and I have completed at least 2 MVP health coaching sessions.	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION AND AUTHORIZATION (this form must be signed below). To the best of my knowledge the information I have entered is correct. I understand that if I enter false information I may be disqualified from the program. **Furthermore, I understand my health plan has the right to review my records to verify my information.**

Subscriber's Signature _____

Date _____

Spouse/Partner Signature _____

Date _____

Any person who knowingly files a reimbursement request containing any misrepresentation or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties. **Return to: MVP New Hampshire HealthFirst, PO Box 1437, Schenectady, NY 12301**