Anthem Health Rewards Health Action Plan

Satisfaction of Wellness Program Alternative Standard

Anthem BlueCross BlueShield

PART 1: REASON FOR THIS FORM

Your employer (or the employer of the person whose name is on the health plan) is offering rewards to employees and their dependents.*

You can receive rewards by achieving certain health outcomes. If you were screened for a wellness program with a target health outcome, but were unable to achieve the health outcome for any reason, you may still apply to get the reward. To do so, you and your doctor must certify that you have met and discussed a health action plan that will help you reasonably work toward the health outcome you were unable to meet. Once you have met, you can apply for the reward by filling out your portion of this form and having your doctor complete his or her portion.

This form is only good for the current plan year of the employer's program. A new form will need to be completed for each plan year. Please keep a copy of the complete form for your records. A form must be filled out for each Wellness Program Health Outcome for which you are requesting a Health Action Plan.

PART 2: FORM TO BE COMPLETED BY MEMBER (employee or dependent)

Last name	First name	Date of birth

Address	City	State	Zip code

Member ID number	Group no.

Health Outcome Program where standard result not met: Tobacco Free

Health Outcome Standard to be met: Not using tobacco products

Your Health Outcome Result: Using tobacco products

By signing this form, I certify that I am not tobacco free and therefore did not achieve the health outcome listed above. I also certify that I have met with my doctor to discuss a health action plan that will help me work towards meeting the health outcome standard. My doctor will confirm this with a signature in Part 3 of this form. I also certify that the information on this form is true and correct.

Member signature X	Print name	Date

PART 3: THIS SECTION IS TO BE COMPLETED BY YOUR DOCTOR

Your patient has indicated he or she has met with you to discuss a health action plan that will help them work towards meeting the health standard listed above. If you agree that a health action plan is in place to support him or her to appropriately work towards the listed health standard, please provide your signature below.

Doctor name	Address	Phone no.

Doctor signature X	Date

PART 4: AFTER FORM IS COMPLETED, MEMBER SUBMITS FORM TO US

Mail To:

(Colorado, Nevada members)	(Indiana, Ohio, Kentucky, Missouri, Wisconsin members)	(New Hampshire, Maine, Connecticut members)
Anthem Blue Cross Blue Shield	Anthem Blue Cross Blue Shield	Anthem Blue Cross Blue Shield
PO Box 5747	PO Box 105557	PO Box 533
Denver, CO 80217	Atlanta GA 30348-5557	North Haven, CT 06473

Write “Health Action Plan” in the lower left corner of the envelope.
This form must be submitted to Anthem no later than 90 days after the end of your plan period.

* Members allowed to participate in Rewards program are at employer's discretion.

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