HEALTHPACT PARTICIPATION COMMITMENT FORM

TUFTS Health Plan

IMPORTANT

In order to qualify for Advantage Level benefits in HEALTHPact, a copy of this form must be completed by each member age 18 and older at the time of renewal.

Please enclose a completed copy of this Annual Renewal Participation Commitment Form for each applicable member on your plan in the envelope we have provided.

Please enclose all required materials for all members on your plan in this envelope and submit it to your employer by the date they have specified.

MEMBER INFORMATION

Note: Members age 18 and older must sign their own form.

1. Member Name: _____

2. Address: _____

3. Preferred Phone Number: ☐ Home: _____ ☐ Cell: _____

4. E-mail Address: _____ 5. Member Identification Number: _____

6. Date of Birth: _____ 7. Today's Date: _____

8. Date of last yearly visit or check-up with PCP: _____

(If that date is not within the last year please put down the date of your next scheduled check-up.)

To qualify for the Advantage Level Benefits, you must confirm your participation in a wellness program(s). Please fill in the appropriate information.

TOBACCO USE

NOTE: "Tobacco use" is defined as the use of a tobacco product or products four or more times per week within no longer than the past 6 months by legal users of tobacco products (generally those 18 years and older) and includes all tobacco products.

☐ YES, I regularly use tobacco products.
☐ NO, I do not regularly use tobacco products.

If YES, please check off actions taken below to help quit tobacco use:

- ☐ Smoking Cessation Counseling Services
- ☐ Prescription Smoking Cessation Medications
- ☐ Over-The-Counter (OTC) Smoking Cessation Products

I confirm that I am participating in a smoking/tobacco cessation program and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program(s).

Member Signature: _____

WEIGHT MANAGEMENT

☐ YES, my PCP recommended that I participate in a weight management program.

☐ NO, my PCP did not recommend that I participate in a weight management program.

If YES, please check off your BMI range and actions taken:

BMI range:

☐ Underweight: BMI is less than 18.5
☐ Normal weight: BMI is 18.5 to 24.9
☐ Overweight: BMI is 25 to 29.9
☐ Obese: BMI is 30 or more

Actions Taken:

☐ Behavior Change/Modification Therapy
☐ Nutritional & Diet Counseling
☐ Weight Loss Medications
☐ Exercise Promotion
☐ Weight Loss Surgery / Bariatric Surgery

I confirm that I am participating in the applicable weight management program(s) as directed by my PCP and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program.

Member Signature: _____

CARE MANAGEMENT/CONDITION MANAGEMENT

☐ YES, Tufts Health Plan recommended that I participate in a Care Management/Condition Management program.

☐ NO, Tufts Health Plan did not recommend that I participate in a Care Management/Condition Management program.

If YES, please note which program(s) you participate in:

☐ Asthma
☐ Chronic Kidney Disease (CKD)
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Complex Care Management
☐ Coronary Artery Disease (CAD)
☐ Diabetes
☐ End Stage Renal Disease (ESRD)
☐ Healthy Birthday
(Members at risk for preterm labor)
☐ Heart Failure
☐ Smoking Cessation
☐ Telephonic Lifestyle or Virtual Coaching
☐ Tufts Health Priority Newborn Care

I confirm that I am participating in the applicable management program(s) as directed by Tufts Health Plan and I understand my participation in the Advantage program is dependent on my engagement in the above mentioned program.

Member Signature: _____