Cleveland Clinic | HealthyChoice

My Personal Program Requirements

Your Health Status is: UNKNOWN

What does it mean if your health status says "Unknown"?

You will not receive a discount in 2025 if your Health Status remains "Unknown."

Your health status is unknown because the health plan doesn't have enough information to determine your health status. Ask your provider to complete and sign a Health Visit Form and submit it as soon as possible but no later than Sept. 30, 2024 so we can assign your health status.

You must submit a Health Visit form as soon as possible and then meet the goals that are set for your specific health status.

What should I do?

Follow these steps to learn your health status and get started:

- ❑ Ask your primary care provider to submit a completed Health Visit form as soon as possible. The health visit form is attached below so you can print it quickly, if needed.
- ❑ View your updated health status and Personal Program Requirements in your portal. More details will be provided on your portal, after your health status is updated.
- ❑ Start participating as soon as possible but no later than Mar. 31, 2024 to be eligible for full credit in 2025. You'll need to actively participate for at least six months and meet all the goals that are set for you by Sept. 30, 2024.

If your health status says HEALTHY:

You'll need to track your physical activity with an approved activity device that is linked to your portal account. Your goal is to reach 180,000 steps or 900 minutes of physical activity each month, for any six months from Jan. 1 through Sept. 30.

If your health status says CHRONIC CONDITION:

You'll need to join a Coordinated Care Program for each condition that's identified for you. Some members in the weight management program will need to participate in an eCoaching program.

NOTE: If you are unable to schedule an appointment with your PCP before Mar. 31, contact the EHP to discuss your options for getting started, such as:

Getting Started with a Chronic Condition: Do you have one of the six chronic conditions that Healthy Choice focuses on, but your Health Visit form hasn't been completed yet? Call 216.986.1050, option 2, to find out if you can enroll in the programs that apply to you.

Getting Started with an Activity Device: If you do not have one of the six chronic conditions, you can start participating with an activity device, but your participation will not count until we determine if you have the Chronic or Healthy status.

Questions? Call **216.986.1050** (option 3) or toll-free at **1.888.246.6648** (option 3).

Under HIPAA, EHP like other health insurers, is permitted to access health data for the purposes of claims payment, health program development and treatment coverage. As with any of our healthcare plans and programs, plan member privacy is protected in full compliance with HIPAA.

For more details about our privacy policies, visit: https://employeehealthplan.clevelandclinic.org/Privacy-Policy.aspx

EHP is committed to helping you achieve your best health. Rewards for participating in the Healthy Choice Premium Discount Program are available to all caregivers and spouses on the health plan. If you think you might be unable to meet a standard for a reward, you might qualify for an opportunity to earn the same reward by a different means. Contact us at **216.986.1050** option 3.

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Health Visit Form

All sections of this form must be completed and signed by a licensed health professional (MD, DO, NP, PA) from your PCP's office and mailed, emailed, or faxed directly to EHP.

DATE OF EXAM (required)

PROVIDER INFORMATION

Last name: _____

First name: _____ Middle initial: _____

Office: _____

Address: _____

Telephone: (_____) _____

PATIENT INFORMATION (required)

Last name: _____ First name: _____ Middle initial: _____

EHP ID: _____ Date of birth: _____

BIOMETRIC DATA (required)

Height: _____ Weight: _____ BMI: _____ Blood pressure: _____

LAB WORK (required)

If under age 40, all individuals should have a baseline panel. If normal, repeat at age 40. For age 40 or older, cholesterol screening must be within last three years.

Date drawn: _____ LDL: _____ LDL:HDL ratio: _____

CHRONIC CONDITIONS (required)

Check Yes if patient has diagnosis. Check No if screen is negative or there is no patient history

Hypertension	❑ YES	❑ NO	Check Yes if BP > 140/90 or on treatment regimen
Diabetes	❑ YES	❑ NO	Check *(if applicable):* ❑ Type 1 ❑ Type 2 Goals for diabetes are BP <130/80 LDL <100
Hyperlipidemia	❑ YES	❑ NO	Check Yes if LDL >130 or on treatment regimen
Asthma	❑ YES	❑ NO	
Overweight/Obese	❑ YES	❑ NO	Check Yes if BMI is 27 or above
Current Nicotine use	❑ YES	❑ NO	Includes smoking, chewing and/or vaping

I authorize my patient to join the applicable physical activity and/or Coordinated Care Program to help maintain or improve their health status.

Provider signature: _____

Please return by mail to:

Cleveland Clinic Employee Health Plan
25900 Science Park Drive, AC242
Beachwood, OH 44122

Email: ehphc@ccf.org
Fax: 216.448.2053

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Formulario de visita médica

Todas las secciones de este formulario deben ser cumplimentadas y firmadas por un profesional sanitario autorizado (médico, osteópata, enfermero, asistente médico) del consultorio de su médico de atención primaria (PCP) y enviadas por correo, correo electrónico o fax directamente al Plan de salud del empleado (EHP).

FECHA DEL EXAMEN (obligatorio)

INFORMACIÓN DEL PROVEEDOR

Apellido: _____

Nombre: _____ Inicial del segundo nombre: _____

Dirección del consultorio: _____

Teléfono: (_____) _____

INFORMACIÓN DE LA PACIENTE (obligatorio)

Apellido: _____ Nombre: _____ Inicial del segundo nombre: _____

Id. del EHP: _____ Fecha de nacimiento: _____

DATOS BIOMÉTRICOS (obligatorio)

Estatura: _____ Peso: _____ IMC: _____ Presión arterial: _____

ANÁLISIS DE LABORATORIO (obligatorio)

Si es menor de 40 años, todas las personas deben tener un panel inicial. Si es normal, repetir al cumplir 40 años de edad. Para personas de 40 años o más, la detección del colesterol debe haberse realizado en los últimos 3 años.

Fecha de la extracción: _____ LDL: _____ Cociente LDL/HDL: _____

AFECCIONES CRÓNICAS (obligatorio)

Marque "Sí" si el paciente tiene diagnóstico, marque "No" si la selección es negativa o el paciente no tiene historial.

Hipertensión	❑ SÍ	❑ NO	Marque "Sí" si la presión arterial es >140/90 o se encuentra en régimen de tratamiento.
Diabetes	❑ SÍ	❑ NO	Marque *(si procede):* ❑ Tipo 1 ❑ Tipo 2 Los objetivos para la diabetes son una presión arterial <130/80 LDL <100
Hiperlipidemia	❑ SÍ	❑ NO	Marque "Sí" si el LDL es >130 o se encuentra en régimen de tratamiento.
Asma	❑ SÍ	❑ NO	
Sobrepeso/obesidad	❑ SÍ	❑ NO	Marque "Sí" si el IMC es 27 o superior.
Consumo actual de nicotina	❑ SÍ	❑ NO	Incluye tabaquismo, masticar tabaco y vapeo.

Autorizo a mi paciente a unirse a la actividad física correspondiente y/o al Programa de atención coordinada para ayudar a mantener o mejorar su estado de salud.

Firma del proveedor: _____

Devuelva por correo postal a:
Cleveland Clinic Employee Health Plan
25900 Science Park Drive, AC242
Beachwood, OH 44122

Correo electrónico: ehphc@ccf.org
Fax: 216.44802053