BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Healthcare Effectiveness Data and Information Set (HEDIS®): Care Opportunities

Compliance Companion Forms

2020

This guide provides insight about HEDIS measures and standards for providing quality medical care.

Our Compliance Companion forms are designed to allow you to communicate to us about the completion of services that we may not have received on a claim. There is a form for all measures on your Care Opportunities report, as long as the measure is eligible for medical record submission. All forms begin by briefly explaining the measure. The forms then provide areas for communicating compliance or exclusion information relevant to the measure. Only the compliance or exclusion pages, along with a cover sheet, need to be sent back to us at the fax number or email address on the bottom of the form. An example form and how to complete it is shown below.

Please fill out your practice information here, so we can identify who rendered the service.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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ABA: Adult Body Mass Index (BMI) Assessment

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual Healthcare Effectiveness Data and Information Set® (HEDIS) effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Completing the information in this box is critical, so we can accurately identify the member.

Compliance Information:

Date of Service: _____ (Current year or the previous year)

Weight: _____ Height: _____ (required for ages 18 and 19)

BMI result: _____ BMI Percentile: _____ (required for ages 18 and 19)

This section will be different on each form. Here, you will enter the information necessary for making members compliant or excluding them from the measure.

Exclusion Information:

Date of pregnancy diagnosis: _____ (Current year or the previous year)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

This signature line is very important. It needs to be filled out on each form. A physical signature, an electronic signature or a provider signature stamp are acceptable.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email** only to HEDIS.Records@bcbssc.com

Whom to Contact

If you have any questions about HEDIS, we can help you. The Quality Improvement team is available to provide you with care opportunity reports, conduct on-site medical record reviews and offer clinical feedback.

If you have questions about your report, please contact your assigned Quality Navigator. If your contact person is not available and you need immediate assistance, please reach out to:

Shannon Montgomery
Manager of HEDIS Projects & Planning
Compliance & Quality Improvement
Phone: 803-382-5825
Fax: 803-419-8191
Email: Navigator@bcbssc.com

If you have questions for your Provider Advocate or need to send other information to BlueCross BlueShield of South Carolina or BlueChoice Healthplan, please contact Provider Education at Provider.Education@bcbssc.com or 803-264-4730.

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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Compliance Forms

Please note that the codes listed herein will result in the closure of an identified care opportunity. This is not a guarantee of benefits or payment. Benefits are always subject to the terms and limitations of the plan. No employee of BlueCross BlueShield of South Carolina or BlueChoice HealthPlan has authority to enlarge or expand the terms of the plan. The availability of benefits depends on the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur automatically under certain circumstances. Benefits will not be available if such circumstances occur.

Please verify eligibility and benefits before providing services. You can do this by using our secure provider portal, My Insurance Manager℠, available at www.SouthCarolinaBlues.com or at www.BlueChoiceSC.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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ABA: Adult Body Mass Index (BMI) Assessment

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual Healthcare Effectiveness Data and Information Set® (HEDIS) effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information:

Date of Service: _____ (Current year or the previous year)

Weight: _____ Height: _____ (required for ages 18 and 19)

BMI result: _____ BMI Percentile: _____ (required for ages 18 and 19)

Exclusion Information:

Date of pregnancy diagnosis: _____ (Current year or the previous year)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

HbA1c or Blood glucose test date: _____ Result: _____

AND

LDL-C test date: _____ Result: _____ **OR** Cholesterol test date: _____ Result: _____

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Exclusion Information

A. Date 1 of schizophrenia diagnosis: _____ Date 2 of schizophrenia diagnosis: _____

B. Date 1 of schizoaffective disorder diagnosis: _____ Date 2 of schizoaffective disorder diagnosis: _____

C. Date 1 of bipolar disorder diagnosis: _____ Date 2 of bipolar disorder diagnosis: _____

D. Date 1 of autism diagnosis: _____ Date 2 of autism diagnosis: _____

E. Other psychotic/developmental disorder diagnosis (name of disorder): _____

Date 1 of other disorder diagnosis: _____ Date 2 of other disorder diagnosis: _____

F. Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

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Practice Address: _____

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AWC: Adolescent Well-Care

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

A visit with a primary care physician (PCP) or OB-GYN practitioner, which includes ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance.

Visit date: _____ (Current year only)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BCS: Breast Cancer Screening

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Mammogram date: _____ (Current year, previous year or on or after Oct. 1 of two years before)

Exclusion Information

Date of bilateral mastectomy: _____

OR

Date of left-sided mastectomy: _____ **AND**
Date of right-sided mastectomy: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Cervical Cancer Screening (CCS)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form. D*o* not count cervical biopsies, because they are not a primary method of cervical cancer screening.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Pap (cervical cytology) test date:_____ Results:_____(Current year or the previous two years for ages 21–64.)

Pap with HPV co-test date: _____ Results:_____(Current year or the previous four years for ages 30-64.)

Exclusion Information

Date of hysterectomy: _____

You are certifying the hysterectomy was “complete,” “total” or “radical,” AND no residual cervix remains.

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider’s Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Comprehensive Diabetes Care

Compliance Form – Page 1

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

HbA1c Testing

HbA1c testing date: _____ (Must be the last known date within the current year)

HbA1c test result: _____

Monitoring for Nephropathy

Urine test for albumin or protein date: _____ (Current year only) Result: _____

OR nephrologist visit date: _____ (Current year only)

OR ARB/ACE inhibitor: _____ Prescription date: _____ (Current year only)

OR Known Conditions

☐ CKD Diagnosis date: _____

☐ ESRD Diagnosis date: _____

☐ Kidney transplant Diagnosis date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Comprehensive Diabetes Care

Compliance Form – Page 2

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Eye Exam (must be completed by an optometrist or ophthalmologist)

Date of funduscopic, retinal or dilated exam: _____

(Current year only unless negative for retinopathy in the prior year as indicated below)

Retinopathy found:

- ☐ Yes
- ☐ No

Date of bilateral eye enucleation noted in medical record: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

Chlamydia Screening in Women (CHL)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Chlamydia test date: _____ (Current year)

Note: Off-label use of birth control does not qualify for exclusion.

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

CIS: Childhood Immunization Status

Vaccinations on or before a child's second birthday.

Compliance Form – Page 1

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form. We require member information and certification boxes for all pages for which you enter compliance information:

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

DTaP Compliance Information (at least four): *Do not count a vaccination administered prior to 42 days after birth.*

Vaccine #1 date: _____ Vaccine #2 date: _____

Vaccine #3 date: _____ Vaccine #4 date: _____

IPV Compliance Information (at least three): *Do not count a vaccination administered prior to 42 days after birth***.**

Vaccine #1 date:_____Vaccine #2 date:_____Vaccine #3 date: _____

MMR Compliance Information (at least one or a combination):

Measles vaccine date:_____AND mumps vaccine date:_____AND rubella vaccine date:_____

History of measles date:_____History of mumps date: _____

History of rubella date: _____

Provider Certification

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Provider's Signature: _____

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Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

CIS: Childhood Immunization Status

Vaccinations on or before a child's second birthday.

Compliance Form – Page 2

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

HiB Compliance Information (at least three): *Do not count a vaccination administered prior to 42 days after birth.*

Vaccine #1 date:_____ Vaccine #2 date:_____ Vaccine #3 date: _____

Hepatitis B Compliance Information (at least three):

Vaccine #1 date:_____ Vaccine #2 date:_____ Vaccine #3 date: _____

History of hepatitis B date:_____

VZV Compliance Information

VZV vaccine date: _____ History of chicken-pox date: _____

Pneumococcal Conjugate Compliance Information (at least four): *Do not count a vaccination administered prior to 42 days after birth.*

Vaccine #1 date:_____ Vaccine #2 date: _____

Vaccine #3 date:_____ Vaccine #4 date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

CIS: Childhood Immunization Status

Vaccinations on or before a child's second birthday.

Compliance Form – Page 3

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Hepatitis A Compliance Information

Hepatitis A vaccine date: _____ Hepatitis A history of illness: _____

Rotavirus Compliance Information (schedule-dependent dosing) *Do not count a vaccination administered prior to 42 days after birth.*

Two-dose vaccine dose #1 date:_____Dose #2 date:_____ **OR**

Three-dose vaccine dose #1 date:_____Dose #2 date:_____Dose #3 date: _____

Influenza Compliance Information (at least two) *Do not count a vaccination administered prior to six months after birth.*

Vaccine #1 date:_____ Vaccine #2 date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

COL: Colorectal Cancer Screening

Compliance Form – Page 1

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information – Option 1 (Colonoscopy)

Date of colonoscopy:_____ (Current year or the previous nine years)

Result: _____

Compliance Information – Option 2 (Flexible Sigmoidoscopy)

Date of sigmoidoscopy: _____ (Current year or the previous four years)

Result: _____

Compliance Information – Option 3 (FIT-DNA)

Date of FIT-DNA completion:_____(Current year or the previous two years)

Result: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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COL: Colorectal Cancer Screening

Compliance Form – Page 2

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information – Option 4 (FOBT)

Type of FOBT test: ☐ gFOBT ☐ FIT Number of samples returned: _____ (up to three samples required)

Dates of FOBT completion: (Current year only) Results:

1) _____ 1) _____

2) _____ 2) _____

3) _____ 3) _____

Compliance Information – Option 5 (CT Colonography)

Date of CT colonography: _____ (Current year or the previous four years)

Result: _____

Exclusion Information

Date of colorectal cancer diagnosis: _____

OR

Date of total colectomy: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

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Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Appropriate Testing for Children With Pharyngitis (CWP)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Group A streptococcus (strep) test date: _____

(Please include ALL dates of service within the past two years.)

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Emergency department visit date for AOD: _____

Outpatient follow-up visit date with a principle diagnosis of AOD: _____

(Must be within 31 days from the date of discharge, to include the day of discharge.)

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Follow-Up After Hospitalization for Mental Illness (FUH)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Date of discharge from inpatient facility with primary diagnosis of a mental illness or intentional self-harm: _____

Outpatient follow-up visit date with a mental health provider: _____

(This form is certifying that the follow-up visit was with a certified mental health provider within 30 days of discharge. NOT to include the day of discharge.)

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Emergency department visit date with a primary diagnosis of a mental illness or intentional self-harm: _____

Outpatient follow-up visit date with a primary diagnosis of a mental illness or intentional self-harm: _____

(Must be within 31 days from the date of discharge, to include the day of discharge.)

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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IMA: Immunizations for Adolescents

Compliance Form

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- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information – Meningococcal

(Date of service must be on or between member's 11th and 13th birthdays.)

Meningococcal conjugate vaccine date: _____

Compliance Information – Tetanus, Diphtheria Toxoids and Acellular Pertussis

(Date of service must be on or between the member's 10th or 13th birthdays.)

Tdap vaccine date: _____

Compliance Information – Human Papillomavirus

(Date of service must be on or between the member's 9th or 13th birthdays and at least 146 days apart.)

HPV vaccine #1 date: _____

HPV vaccine #2 date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
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BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

LBP: Imaging Avoidance — First Four Weeks of Low Back Pain

Exclusion Form

Use this form to let us know that a member may not be appropriate for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Exclusion Information – Competing Diagnoses

☐ Cancer/malignant neoplasm ☐ HIV

☐ Recent trauma ☐ Spinal infection

☐ Neurologic impairment ☐ Major organ transplant

☐ IV drug abuse

Date of diagnosis: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

MPM: Annual Monitoring for Patients on Persistent Medications

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Serum potassium date:_____ (Current year only)

AND

Serum creatinine date:_____ (Current year only)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

Medication Reconciliation Post-Discharge (MRP) and Transitions of Care (TRC)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Notification of inpatient admission date: _____
(This is certifying that the PCP was notified of the member's admission AND it was documented in the member's outpatient record on the day of or day following admission.)

Receipt of discharge information date: _____
(This is certifying that the PCP received discharge information on the day of discharge or day following to include ALL of the following components: name of practitioner responsible for member while inpatient, all procedures or treatments provided during the inpatient stay, diagnosis at the time of discharge, current medication list, all testing results [to include if results are still pending or no tests were ordered] AND instructions to the PCP for patient care.)

Medication reconciliation date: _____
(This is certifying that all discharge and current medications were reconciled on this date of service. Must be completed within 30 days of discharge.)

Patient engagement date: _____
(This is certifying that the member was engaged in person or via telehealth on this date of service. Must be completed within 30 days of discharge.)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

Exclusion Form

Use this form to let us know that a member may not be appropriate for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Exclusion Information – Competing Diagnoses

☐ Cervical cancer

☐ HIV

☐ Immunodeficiency

☐ Hospice

Date of diagnosis: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

OMW: Osteoporosis Management in Women Who Had a Fracture

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Bone mineral density test date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

PPC: Prenatal and Postpartum Care

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Provider Type: ☐ PCP ☐ OB-GYN Pregnancy diagnosis date: _____

Prenatal visit date: _____ EDD date: _____

Postpartum visit date: _____ Delivery date: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____ Last Name: _____

Compliance Information

Spirometry test date: _____

(Please include ALL dates of service within the last two years.)

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Use of Opioids From Multiple Providers (UOP)

Exclusion Form

Use this form to let us know that a member may not be appropriate for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Exclusion Information

Date member entered hospice care: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

W15: Well-Child Visits in the First 15 Months of Life

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Visits with a primary care physician (PCP) in which the visit included ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance:

Visit date #1: _____ Visit date #2: _____

Visit date #3: _____ Visit date #4: _____

Visit date #5: _____ Visit date #6: _____

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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W34: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

A visit with a primary care physician (PCP), which includes ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance.

Visit date: _____ (Current year only)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

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WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Compliance Form

Use this form to let us know about any care opportunities you may have closed for this measure. Doing so allows us to:

- Reduce the number of record requests you receive during the annual HEDIS effectiveness of care audit.
- Target our educational outreach to members who need preventive or health services.

Please complete this form.

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Compliance Information

Nutrition counseling date: _____ (Current year)

Physical activity counseling date: _____ (Current year)

Date of BMI percentile: _____ (Current year)

Height: _____ (in inches) Weight: _____ (in pounds) BMI percentile: _____
(Must be a distinct number and not a range.)

Exclusion Information

Date of pregnancy: _____ (Current year only)

Provider Certification

This document contains a true and accurate account of the services rendered to this patient and constitutes part of the legal health record.

Provider's Signature: _____

A provider signature stamp is an acceptable signature.

Once completed, please fax to 803-419-8191, Attn: HEDIS,
or **send by secure email only** to HEDIS.Records@bcbssc.com.