Dear Member:

Thank you for selecting Blue Cross Blue Shield of Arizona Advantage (HMO) as your health plan. We are pleased to welcome you as a new member.

In order to get to know you and the services you might need, we have included a questionnaire that we ask each new member to fill out. Your answers will help us understand if you need additional health and medical services in addition to the services provided by your Primary Care Physician. Please be assured that your responses to these questions will be kept confidential.

Once a Medical Services staff member reviews your information, they may call you if they have any questions.

Thank you again for choosing Blue Cross Blue Shield of Arizona Advantage (HMO). We look forward to supporting you and your healthcare needs.

Sincerely,

Dr. Mehrdad Shafa, M.D.
Chief Medical Officer

Please call Member Services at toll-free at (800) 446-8331. TTY/TDD users should call 711. We are available from 8:00 a.m. to 8:00 p.m., Monday–Friday from February 15 to September 30; and 7 days a week from October 1 to February 14.

This information is available for free in another language. Please call our Member Services at the number listed above.

Esta información está disponible gratis en otra lengua. Por favor póngase en contacto con la llamada nuestros Servicios de Miembro en el número puesto en una lista encima

If you have special needs, this document may be available in another format.

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Initial Assessment Questionnaire

BlueCross BlueShield of Arizona Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Member Name: _____ Member ID # _____

Selected PCP: _____ PCP Network: _____

Effective Date: _____

1. What is your preferred language? *(Optional)*

   ☐ English ☐ Spanish ☐ Other_____*(Specify)*

2. Do you need an interpreter? ☐ Yes ☐ No

3. Was your selected Primary Care Physician your doctor before enrolling in this health plan?

   ☐ Yes ☐ No

4. When was your last office visit with either a Primary Care Physician or a Specialist?

   Approximate date: _____

5. Have you been told by a doctor that you have any of the following medical conditions? *Check all that apply.*

   ☐ Diabetes ☐ Heart Disease (Congestive Heart Failure)

   ☐ Heart Attack ☐ High Blood Pressure (Hypertension)

   ☐ Emphysema (COPD) ☐ End Stage Kidney (Renal) Disease with Dialysis

6. Are you currently receiving any of the following services? *Check all that apply and note who is providing the service.*

   ☐ Physical therapy Provider: _____

   ☐ Occupational therapy Provider: _____

   ☐ Speech therapy Provider: _____

7. If you are currently receiving any oxygen services, ostomy supplies and/or any other rented medical equipment (wheelchair, walker, etc.), please provide the following.

   Company name(s): _____

   Phone number(s): (___) _____ (___) _____ (___) _____

8. If you have scheduled an appointment with a Specialist, please provide the doctor's name and the date of your next appointment.

   Doctor: _____ Date of appointment: _____

9. If you have any surgeries scheduled, please provide the name of the doctor, name of the procedure, and the date for the procedure.

   Doctor: _____ Procedure name: _____

   Procedure date: _____

10. If you have had an organ transplant, please provide the following.

    Type of organ transplant: _____ Date of organ transplant: _____

11. If you are currently receiving treatment for mental/behavioral health conditions, such as depression or anxiety, please provide who you are receiving services from.

    Name: _____ Phone number: _____

12. If you are receiving any Home Health Care, please provide the following.

    Company's name: _____

    Phone number: (____) _____

13. If you are currently residing in a nursing facility to assist you with your activities of daily living, please provide the name and phone number of the facility.

    Facility name: _____

    Phone number: (____) _____

14. If you are receiving care from a VA doctor, please provide the following.

    Doctor's name: _____

    Phone number: (____) _____

15. If you are currently enrolled in the Arizona Long Term Care Services (ALTCS) program please provide the name of your ALTCS plan: _____

16. Do you have any of the following documents completed? *Check all that apply.*

    ☐ Medical Power of Attorney ☐ Living Will

    ☐ Durable Power of Attorney ☐ Mental Health Power of Attorney

    ☐ Advanced Directive

17. Would you like information on any of the documents mentioned above?

    ☐ Yes ☐ No

18. What is your race/ethnicity? *(optional)*

    ☐ White ☐ Hispanic ☐ Native American ☐ Black/African American ☐ Asian/Pacific Islander

    ☐ Other _____

(Optional)
You may be eligible to receive additional medical and pharmacy benefits under the Medicaid/AHCCCS program. You also may be able to have your Part B premium paid by the Medicaid/AHCCCS program resulting in an increase in your social security check. Would you like a call to see if you qualify for a Medicare Savings Program? ☐ Yes ☐ No

Thank you for completing this questionnaire. Please return it to Blue Cross Blue Shield of Arizona Advantage as soon as possible in the enclosed postage-paid envelope.

If you have any questions or need assistance,
please call Member Services at **(623) 974-7430**,
or toll-free at **1-800-446-8331. TTY/TDD** users should call **711**.

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