Diabetes Program Enrollment Questionnaire

Please complete this questionnaire with as much information as possible

Demographic Information
Name:
Insurance ID#:
Address:
City/State/Zip Code:
Date of Birth:
Age:
Race:
Sex: Male Female
Are You Married? Yes No
Highest Level of Education Completed: 1 2 3 4 5 6 7 8 9 10 11 12 Associate's Bachelor's Master's Doctorate

Contact Information
Provide your contact information below: Phone: Home _____ Cell _____ Work _____ Email Address:
List your preferred modes of contact: First Choice: _____ Second Choice: _____
What is the best time of day to reach you?
Doctor's Name: Doctor's Phone Number:
Who manages your diabetes care? Primary Care Physician (PCP) Endocrinologist
Is there someone you would like us to discuss your care with? Yes No If yes, please provide their name and relationship below. Contact Name: Relationship:
How did you hear about the Diabetes Management program? (Circle One) Benefits Call Human Resources Clinic Health Fair Doctors Office Hospital Other: _____
What is your primary language? If your primary language is not English, do you need an interpreter for calls? Yes No
Employment Information
What is your employment status? Full-Time Part-Time Unemployed
Describe the kind of work you do if you are employed.
Are you an employee of Smithfield Foods? Yes No
Is Smithfield Foods your primary insurance coverage? Yes___ No____ If no, what is your primary coverage?

Basic Diabetes Information
When were you diagnosed with diabetes? Month: Year:
Which type of diabetes do you have? Type 1 Type 2
What is your most recent Hemoglobin A1C lab test result (checked by your doctor)? Month/Year tested: A1C result:
How often do you have your A1C tested?
What does your doctor want your A1C to be?
Do you have a glucometer? Yes No If yes, what kind?
How often do you check your sugar? (Circle one) Weekly Daily 2-3 times per day 4-6 times per day 7 or more times per day
Have you had any low blood sugar readings/hypoglycemic reactions in the last year? Yes No If yes, what was the reading?
Have you ever worked with a dietician/nutritionist? Yes No If yes, when?
Have you ever taken diabetes education classes? Yes No
How often do you exercise? Not Active 1-3 times a week 4 or more times a week
What was your last blood pressure reading and when was it taken? Blood Pressure Reading: Date Taken:
What was your last cholesterol reading and when was it taken? Total: Triglycerides: HDL: LDL: Date Taken:
What is your weight?
What is your height?
When was your last eye exam? Month: Year:
Have you had any vision changes related to your diabetes? Yes No If yes, explain:
When was your last foot exam? Month: Year:
Have you had any numbness, tingling or pain in your feet/legs? Yes No
Do you feel you are doing a good job managing your diabetes? Yes No Explain:

PLEASE COMPLETE THE FOLLOWING ABOUT YOUR HEALTH HISTORY

Do you have any of the following health conditions?	**Yes**	**No**	**Briefly Explain**
Heart Disease- ex: Heart attack, chest pain, pacemaker			
Lungs/Breathing-ex: asthma, COPD			
Stomach/Bowel			
Blood Disorders-ex: anemia, sickle cell			
Muscle/Bones/Joints- ex: arthritis, joint replacement			
Kidney disease			
Cancer			
Diabetes			
Stroke			
Mental Health or Substance Abuse			
Have you been hospitalized in the **past year**?			

Medications *(Please include prescriptions, over the counter medications vitamins and supplements)*	***Dosage*** *(milligrams, micrograms, units, etc.)*	***How often do you take it?*** *(once a day, twice a day, etc.)*	***What is the medication intended to treat?*** *(high blood pressure, diabetes, etc.)*
Where do you fill your medications?			

General Health Information
Do you get an annual flu shot? Yes No
Have you ever had the pneumonia vaccine? Yes No
When was your last dental exam? Month: Year: Do you have dental coverage through the Smithfield Health Plan? Yes No If no, would you consider asking about the dental coverage at your next open enrollment? Yes No
Do you smoke? Yes No Previously *If yes, the Smithfield Benefits office has information on the Smoking Cessation program available through your health plan. Please call 1-800-809-5916 for more information.*
During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes No
During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Note:

- To be an active member of the Diabetes Management program, you must provide at least two A1C results each year and be available for periodic contact by the nursing staff.
- The frequency of contact by the nursing staff is based on your A1C results.
- Staff is available to assist you Monday through Friday 8:30 am to 6:00 pm.
- Please note: enhanced benefits of this program will not be active until your complete enrollment package is received including your signed consent form. Staff will reach out to notify you of activation.
- Please sign the attached consent form and you may make a copy for yourself. You can fax to (757)562-3537 or mail it to the address listed below:

Mid-Atlantic Health Solutions
Diabetes Management Program
PO Box 494
Franklin, VA 23851
(800) 570-4888

I certify this information provided above is true and correct to the best of my knowledge.

Signature _____ Date _____

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MID ATLANTIC
HEALTH SOLUTIONS

CONSENT FOR DIABETES PROGRAM MANAGEMENT AND RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____

DATE OF BIRTH:_____

In order to allow my case manager to assist me with my health care needs and to discuss those needs with my health care providers, I give permission for Mid-Atlantic Health Solutions:

1. To contact my health care providers in regards to my medical needs in order to assist in the development of my Diabetes Management Plan.
2. To receive medical information about my condition including but not limited to treatment plans and laboratory results related to my diabetes management.
3. To release verbal or written information that is related to my medical condition(s) to my health care providers in order to ensure a complete picture of my health care needs with the understanding that this information will assist in the coordination of my care.

This authorization will be valid for the complete period of time that I am enrolled in the Diabetes Management Program. I understand that any protected health information that is communicated between my health care providers and Mid-Atlantic Health Solutions will be held in strict confidence and shall be used only for the purpose of case management.

My signature on this document represents that I understand in order to participate in the Diabetes Management Program that I must actively participate and provide Hemoglobin A1C results to my case manager at requested intervals. I further understand that participation in the program is completely voluntary and that I can choose not to participate at any time by telling my case manager I desire to withdraw from the program. Upon my request to withdraw from the Diabetes Management Program, this authorization form is automatically null and void.

I agree with all the above conditions and wish to participate in the Diabetes Management Program.

PATIENT SIGNATURE: _____ **DATE:** _____

***NOTE: If patient is less than 18 years of age, parent or legal guardian must sign consent below:**

PRINTED NAME OF PARENT/LEGAL GUARDIAN_____

SIGNATURE OF PARENT/LEGAL GUARDIAN_____

DATE: _____

Please sign, date and return this form and the enrollment questionnaire. You may make a copy for your records. You may also fax to 757-562-3537 Thank you.

10/2018

2018/2019 Diabetes Management Program
Enhanced Program Benefits with an In-Network Provider

- Educational materials
- One on one guidance with a diabetes program nurse
- 100% benefit coverage for:
  - ✓ One Touch glucose monitoring device with a prescription (one per plan year)
  - ✓ Diabetic testing and injection supplies with a prescription
  - ✓ Four office visits (one per 90 day period) to your primary care doctor or endocrinologist for diabetes follow up
  - ✓ Hemoglobin A1C testing (once per 90 day period)
  - ✓ A lipid test, retinal eye exam, and foot exam each plan year
  - ✓ Six nutrition counseling visits per plan year

- 90% benefit coverage after annual deductible for:
  - ✓ Insulin pumps and continuous glucose monitors (CGM) and supplies

- Enhanced benefit for diabetes medications:
  - ✓ 100% benefit coverage for generic diabetic medications
  - ✓ 100% benefit coverage for **insulin** provided under your Optum formulary
  - ✓ 95% benefit coverage for **preferred brand** diabetic medications. Member's 5% co-pay capped at $100 max for 30 day supply and $200 max for 90 day supply.
  - ✓ 90% benefit coverage for non-preferred brand diabetic medications. Member's 10% co-pay capped at $125 max for 30 day supply and $250 max for 90 day supply.

To enroll in the Diabetes Program – Call Mid-Atlantic Health Solutions at (800) 570-4888, Monday through Friday, 8:30 am to 6:00 pm ET or download an enrollment form at www.mahsolutions.com. (interpreter line available)

For pharmacy/formulary questions, check with your Pharmacy Benefit Manager (PBM), OptumRx by calling (877) 358-6395 or at www.optumrx.com.

Para obtener información sobre este programa o si desea participar, llame a Mid-Atlantic Health Solutions al 1-800-570-4888. Una línea de intérprete está disponible.

Rev. 11/2018