

MEDICAL MANAGEMENT FORM

Member Name: _____

Member ID: _____

✚ Has the member seen their PCP in the past 12 months? YES NO

✚ Name of PCP seen: _____

✚ Did the member have problems getting an appointment with the PCP? YES NO

✚ Has the member used the Emergency Room for medical reasons more than twice in the past 6 months? YES NO

✚ If the member is a woman over 21, has she had a Pap Smear in the past 3 year? YES NO

✚ If the member is a woman over 40, has she had a Mammogram in the past year? YES NO

ILLNESS MANAGEMENT

✚ Does the member have a chronic medical condition for which a doctor has recommended visits at least twice Per year? YES NO

✚ If yes, visits kept? YES NO

✚ If the member has a chronic illness, have they been prescribed medication? YES NO

✚ If yes, is he/she adhering to the prescription? YES NO

✚ Does the member have asthma for which they have seen the doctor in the past year? YES NO

✚ If yes, is he/she adhering to the prescription? YES NO

✚ Does the member have diabetes? YES NO

✚ If yes, does the member know the value of their last A1c test? YES NO

✚ If yes, was the value less than 8? YES NO

Actions Recommended: _____

