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

2021MY

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

Our Compliance Companion forms allow you to communicate with us about the completion of services 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. You only need to send the compliance or exclusion pages, along with a cover sheet, back to us at the fax number or email address on the bottom of the form. An example form and how to complete it are 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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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: _____

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

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: _____

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.

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 is 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:

HEDIS Projects & Planning Compliance & Quality Improvement
Fax: 803-419-8191
Email: Navigator@bcbssc.com

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

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Compliance Forms

Please note 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: _____

Hospice or Palliative Care All-Measure Exclusion

Exclusion Form

Use this form to let us know we may need to exclude a member from all measures due to hospice or palliative care in the measurement year. 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: _____*(Current Year Only)*

OR

Date member received end-of-life palliative care: _____*(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.

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or **send by secure email only** to HEDIS.Records@bcbssc.com.

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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

AMO: Annual Monitoring for Persons on Long-Term Opioid Therapy

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 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: _____

Indicate at least one of the following drug screens/tests from the following targeted drug classes:

☐ Amphetamines ☐ Cocaine

☐ Barbiturates ☐ Opiates/opioids

☐ Benzodiazepines

☐ Cannabinoids

Date(s) of screens/tests: _____ *(Current year only)*

Please list all known drug screen/test dates for the current year

Provider Certification

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Provider's Signature: _____

A provider signature stamp is an acceptable signature.

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or **send by secure email only** to HEDIS.Records@bcbssc.com.

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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 prior to current year)

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.

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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

CBP: Controlling High Blood Pressure

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

Systolic reading: _____ Date of Service: _____

Diastolic reading: _____ Date of Service: _____

(Must be the last recorded blood pressure reading of the current year)

Exclusion Information – You must check at least one box and enter a date for consideration.

☐ Kidney transplant*

☐ End-stage renal disease*

☐ Dialysis*

☐ Nephrectomy*

☐ Pregnancy *(During the current year only)*

Date of diagnosis or procedure: _____

**Any time during the member's history through Dec. 31 of the current 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,
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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CCS: Cervical 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. 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.)

HPV (Human Papilloma Virus) test date: _____ Results: _____(Current year or the previous four years for ages 30 – 64.)

Exclusion Information

Date of hysterectomy/cervical absence: _____

You are certifying the hysterectomy was "complete," "total" or "radical," OR no cervix is present.

Provider Certification

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Provider's Signature: _____

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or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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CDC: Comprehensive Diabetes Care

Compliance Form – Page 1 of 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: _____

HbA1c Testing

HbA1C testing date: _____ *(Must be the last recorded A1C of 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: _____ *(Current year only)*

☐ ESRD Diagnosis date: _____ *(Current year only)*

☐ Kidney transplant Diagnosis date: _____ *(Current year only)*

Provider Certification

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Provider's Signature: _____

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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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CDC: Comprehensive Diabetes Care

Compliance Form – Page 2 of 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: _____

Diabetic Retinal Eye Exam

1) Date of funduscopic, retinal or dilated exam: _____
(Current year only unless negative for retinopathy in the prior year, as indicated below)

AND

2) Retinopathy found:
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

AND

3) Diabetic retinal screening read or performed by (*select one)*:
   - ☐ Optometrist
   - ☐ Ophthalmologist
   - ☐ Artificial intelligence

-OR-

1) 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.

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Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

CHL: Chlamydia Screening in Women

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)* Chlamydia test result: _____

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.

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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 of 3

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:_____Mumps vaccine date:_____ Rubella vaccine date:_____

OR

History of measles date:_____History of mumps date: _____History of rubella 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: _____

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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 of 3

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: _____

OR

History of hepatitis B 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: _____

VZV Compliance Information

VZV vaccine date: _____ **OR** History of chickenpox 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 of 3

Member Information

ID Card Number: _____ Date of Birth: _____

First Name: _____ Last Name: _____

Hepatitis A Compliance Information

Hepatitis A vaccine date: _____ **OR** 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 of 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: _____

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 (DNA Biomarker Test)

Date of FIT-DNA (DNA Biomarker Test) 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,
or **send by secure email only** to HEDIS.Records@bcbssc.com.

Practice Name: _____

Practice Tax ID: _____

Practice Address: _____

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COL: Colorectal Cancer Screening

Compliance Form – Page 2 of 2

Member Information

ID Card Number: _____ Date of Birth: _____

First Name:_____Last Name: _____

Compliance Information – Option 4: FOBT

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

Dates of FOBT completion:	Results:
1):_____*(Current year only)*	1):_____
2):_____*(Current year only)*	2):_____
3):_____*(Current year only)*	3):_____

Compliance Information – Option 5: CT Colonography

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

Result: _____

Exclusion Information *(Any time during the member's history through Dec. 31 of the current year)*

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: _____

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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CWP: Appropriate Testing for Pharyngitis

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: _____ Result: _____

Group A streptococcus (strep) test date: _____ Result: _____

Group A streptococcus (strep) test date: _____ Result: _____

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

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

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.)

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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FUH: Follow-Up After Hospitalization for Mental Illness

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.)

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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FUM: Follow-Up After Emergency Department Visit for Mental Illness

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.)

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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IET: Initiation and Engagement of Alcohol and/or Other Drug Abuse or Dependence Treatment

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: _____

Date of New Episode of Alcohol and/or Other Drug Abuse or Dependence (AOD) Diagnosis:

Diagnosis date: _____ AOD diagnosis: _____

Compliance Information – Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis

Date of initiation of AOD treatment*: _____

**Date must be within 14 days of the diagnosis date listed above.*

Compliance Information – Engagement of AOD Treatment: The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of initiation visit

Date of engagement of AOD treatment*: _____

**Date must be within 34 days of the initiation date listed above.*

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

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 – Meningococcal

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

Meningococcal conjugate 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: _____

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: _____

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

INR: International Normalized Ratio Monitoring for Individuals on Warfarin

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

List all International Normalized Ratio (INR) dates of service within the measurement year and results.

INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR result:_____
INR date:_____	INR result:_____	INR date:_____	INR 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: _____

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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: _____

LBP: Imaging Avoidance — *Use of Imaging Studies for 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.

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

Prenatal visit date: _____

Postpartum visit date: _____

Pregnancy diagnosis date:_____

EDD/EDC 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

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W30: Well-Child Visits in the First 30 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: _____

Well-Child Visits in the First 15 Months of Life

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

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

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

You are certifying the dates documented were with a primary care physician (PCP) and included ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance.

Well-Child Visits in the 15th Month of Life Through the 30th Month of Life

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

You are certifying the dates documented were with a primary care physician (PCP) and included ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance.

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

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/ ☐cm Weight: _____ ☐lbs/ ☐kg 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.

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

WCV: Child and Adolescent Well-Care Visits

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

Visit date: _____ *(Current year only)*

You are certifying the dates documented were with a primary care physician (PCP) and included ALL of the following components: health history, physical developmental history, mental developmental history, physical exam and health education/anticipatory guidance.

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.

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