BlueCross BlueShield of Western New York

The Good Life® Physician Verification Form

Instructions to complete this form:

1. Please complete all fields. Use blue or black ink. Print one character per box.
2. Do not send any additional information attached with this form.
3. **You must complete and return the original form, September 30, 2019** to the following address:

   BlueCross BlueShield of Western New York
   Attn: *The Good Life*
   PO Box 80
   Buffalo, NY 14240-0080

   Or completed form can be emailed to **thegoodlife@bcbswny.com**
4. Please keep a copy of this form for your records.

1 — Member Information

Please complete this form with your physician if you are not participating in a worksite health screening. Member: If you have any questions please contact customer service at 1-800-544-2583.

Member's Last Name | **Member's First Name** | **M.I.**

Member's ID | **Suffix** | **Group Number** | **Date of Birth (MMDDYYYY)**

Member's Signature

2 — Physician Information

Your patient is part of a health plan that asks him/her to have a health screening and complete a Health Assessment. Please take a moment during the office visit to complete this form and return it to your patient. If you have any questions please contact Provider Service at 1-800-950-0051.

Health Screening Information

Please enter the following measurements for your patient. **Results not permitted before October 1, 2018**

Height (inches) | **Weight** (pounds) | **Blood Pressure:** **Systolic** | **Diastolic**

Blood Sugar | **Total Cholesterol** | **LDL** | **HDL** | **Triglycerides**

Attending Physician's Last Name | **Attending Physician's First Name** | **M.I.**

Attending Physician's Signature | **Date (MMDDYYYY)**

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