



City of Newton

PROVIDER CONFIRMATION FORM

Please enter the dates your patient last had the following pre-diabetes/diabetes exams and/or laboratory work completed based on your contact with the patient and available medical records. By completing all recommended exams and lab-work, your patient will be eligible to receive diabetes medications and supplies for \$0 copays. If you do not feel it is medically necessary for your patient to have one of the exams/labs below **within the next 12 months**, simply check that box for the exam/lab, and they will receive credit for the activity. The information you are providing will be retained by the **Good Health Gateway**® administrators of this incentive program on behalf of your patient's health plan sponsor, City of Newton. HIPAA privacy and security standards are used to ensure the security of your patient's healthcare information.

PATIENT NAME	DOB / /
HEALTH PLAN ID NO.	TEL. () -

DIABETES CARE ACTIVITY	NOT NEEDED IN NEXT 12 MONTHS	DATE LAST COMPLETED					
		MONTH		DAY		YEAR	
Diabetes Eye Exam	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diabetes Foot Exam	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Laboratory Work-up of Fasting Blood Lipid	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Laboratory Work-up of Urine/Protein Levels	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Laboratory Work-up of Hemoglobin A1c levels	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Most Recent Hemoglobin A1c Value Most Recent Blood Pressure Value

Practice Name (Please print): _____

Provider Telephone Number: _____

Provider Name (Please print): _____

Provider Signature: _____

Date:

Please complete all the information you can, sign, date, and fax to Abacus.
Toll-free (877) 378-4480 *Thank you for your assistance!*



Managing your health has its own Rewards.
Plus, we'll give you a few more.

Dear Dr./Healthcare Provider:

Your patient is participating in a voluntary incentive program offered through his or her employer and/or health plan sponsor.

The program is designed to encourage your patient's adherence to pre-diabetes/diabetes care guidelines, including regular tracking of their pre-diabetes/diabetes as well as adherence to any prescribed medication regimens, and thereby achieve better health outcomes and reduced health care costs.

If your patient demonstrates (through your certification on the attached fax-back form) that they are up to date with all the following elements of their care, they will be able to get their **diabetes medications and supplies for \$0 copays**, including brand as well as generic diabetes medications and supplies including insulin needles, syringes, test strips, lancets, and glucometers:

- Annual foot exam (last exam within the past 12 months)
- Annual eye exam (last exam within the past 12 months)
- Annual fasting blood lipid levels (last lab within the past 12 months)
- Annual urine protein levels (last lab within the past 12 months)
- Semiannual HbA1c levels (last lab within the past 6 months)

If all items are not up to date at this office visit, you can order the missing items, and fax the form upon their completion, so that your patient can qualify as soon as possible for \$0 copays on their diabetes medications and supplies. If you do not feel that your patient needs a particular lab/exam **in the next 12 months**, simply check not needed, and they will receive credit for this activity. If your patient is seeing multiple health care providers for their pre-diabetes/diabetes and you can only complete some items, that is OK, please complete those items you can.

We acknowledge, and communicate to the patient, that these care activities are minimum requirements that need to be completed on an ongoing basis, and that you may recommend more frequent or additional examinations, testing, and other procedures or treatments as needed.

Thank you very much for your assistance on behalf of your patient, and if you have questions feel free to contact us at (800) 643-8028.

Sincerely,

Amy Bickford
Senior Director, Client & Member Services