HMO Illinois / BlueAdvantage HMO
Physician Condition Management Enrollment Form

Date: ☐☐/☐☐/☐☐☐☐

Patient Last Name: ☐☐☐☐☐☐☐☐☐☐

Patient First Name: ☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

BCBSIL ID Number: ☐☐☐☐☐☐☐☐☐

Patient Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City **State** **Zip code**
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐

IPA Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

IPA Number: ☐☐☐

Physician Name: ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐

Please enroll this patient in the following HMO Condition Management Program(s):

Asthma ☐

Cardiovascular Conditions ☐

Diabetes ☐

_____
Physician Signature

Please note that the member will be added to the Educational Materials mailing list for the requested program.

Please return the completed form to the Quality Improvement Department.
Fax: 312-228-9058, or
E-mail: tammy_i_fisher@bcbsil.com