UnitedHealthcare Pledge Plan℠

a HEALTHpact plan

Primary Care Physician Checklist for Adolescents (12 - 17)

To Be Completed By Primary Care Physician

IMPORTANT: In order to retain Advantage-level benefits in the UnitedHealthcare Pledge Plan℠, a HEALTHpact plan, this form must be completed by your adolescent's primary care physician (PCP) for each adolescent (ages 12 to 17 at the time of enrollment) member and mailed by the member to:

UnitedHealthcare
475 Kilvert St.
Warwick, RI 02886

Mail no later than 240 days (eight months) after enrollment. If we do not receive these forms for all adult family members within **240 days** of enrollment, the entire family shall receive Basic-level benefits in Year 2.

Member Name: _____

Address: _____

Member ID Number: _____

Date of Birth: _____

Date of Examination: _____

Body Mass Index

1. Body Mass Index (BMI) calculation
   a. Weight: _____
   b. Height: _____
   c. BMI: _____

2. The member's BMI is above his/her recommended BMI level: Yes ☐ No ☐

3. If the member's BMI is above the recommended level, has the physician discussed a weight loss program or goal with the member? Yes ☐ No ☐ (leave blank if member's BMI is not above recommended level).

4. Briefly describe the program or goal: _____

_____

_____

_____

5. Additional comments: _____

_____

_____

_____

Smoking

1. Is the member a smoker (has he or she smoked at all within the last 6 months): Yes ☐ No ☐

2. If the member is a smoker, has the physician discussed a smoking cessation program or goal with the member and the member's parent or guardian? Yes ☐ No ☐ (leave blank if member is not a smoker).

3. Briefly describe the program or goal: _____

_____

_____

4. Additional comments: _____

_____

_____

Physician Signature (Required)

The information supplied above is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Physician Name (printed): _____

Member Signature (Required)
(To be signed by Parent or Guardian)

I have reviewed and discussed the information supplied above with my adolescent's physician, and I agree to comply with his/her recommendations. I understand that submission of this PCP Checklist is required in order to continue in Advantage-level benefits under my UnitedHealthcare Pledge Plan.

Signature: _____ Date: _____

UnitedHealthcare Pledge Plan
Dedicated Service Line
1-800-573-0414

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