



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Medical Waiver Request

Physician instructions: If your patient is unable to meet the clinical criteria documented on the qualification form for one of the reasons below, please check the appropriate box and complete the *Physician sign-off* section. The member must also complete the *Member Instructions* section before faxing this to Blue Cross Blue Shield of Michigan.

- Member is pregnant
- Member is in hospice

If the circumstances above do not apply to your patient, but it is medically inadvisable or unreasonable for the patient to achieve the health measure criteria for any other reason, please complete the entire form and return it to the member for submission to Blue Cross Blue Shield of Michigan.

The member is unable to meet the following criteria: (check all that apply)

Please indicate the medical condition or reason for the waiver

<input type="checkbox"/>	Tobacco Not a tobacco user (never used or quit >1 month)	
<input type="checkbox"/>	Weight Body mass index <30	
<input type="checkbox"/>	Cholesterol ≤160 mg/dl (LDL)	
<input type="checkbox"/>	Blood pressure ≤140/90	
<input type="checkbox"/>	Blood sugar A1c < 8% (diabetic)	

Physician sign-off: I verify the information supplied is complete and accurate.

Physician last name	Physician first name	National provider identifier
Physician signature	Physician telephone number	Date

Member Instructions: If your physician has verified that it is medically inadvisable or unreasonable for you to meet one or more of the health criteria required by your program, you must complete the following steps:

- Fax the completed form to 1-877-885-2596.**
- Review the letter that will be sent about five business days after you fax your waiver. If you do not receive a letter within two weeks, please call BCBSM at 1-800-775-BLUE (2583).
- Complete the tasks detailed in your alternate compliance letter by the dates specified in the mailing, if appropriate.

Member last name	Member first name
Contract or enrollee ID number (example: ABC 123456789)	Group number (five or nine-digit number)
Telephone number	Date of birth (MM/DD/YYYY)
Member signature	Email address