Lucas County Patient Centered Medical Home Program
Partnership Agreement (PA)

PATIENT: Once you and your physician both sign the Partnership Agreement, **YOU** are responsible for sending the form into Paramount so that your incentive can be earned. The best way to get the form to us is through fax at **800-990-7762** or Email to Steps2Health@ProMedica.org. **Please keep a copy of both your PA and fax confirmation.** If you prefer mailing it send to: Paramount/PA INFO, PO Box 928, Toledo, OH 43697-0928 .

MEMBER ID: _____ DATE OF AGREEMENT: _____

MEMBER NAME: _____ DOB: _____

PROVIDER NAME AND ID NUMBER: _____

If Provider name and ID number are not present on this form, it cannot be processed

This partnership agreement confirms the commitment of me and my provider to work together and establish personal health care goals to support my health and well-being. <u>This agreement was reviewed and completed as part of a wellness visit.</u>

My PERSONAL HEALTH CARE GOALS for this year are:

1. _____
2. _____
3. _____

I/Patient have the following condition(s) and a follow up appointment has been scheduled. (Mark all that apply)	
☐	Asthma
☐	Chronic Kidney Disease
☐	Chronic Obstructive Pulmonary Disease
☐	Coronary Artery Disease
☐	Diabetes
☐	Depression
☐	Hypertension

Please Note: Disease Management Programs may be recommended by Paramount or the Provider

Must meet with my Provider again within: 60 days ☐ 90 days ☐ 180 days ☐ 365 days ☐ (Next Annual Physical)

PATIENT

I am committing to this partnership with my Provider and to working towards a healthier me. I will begin working towards achieving the goals and programs defined in this appointment and in any other appointments we have during the year. **If I choose NOT to meet with my PCP for an annual physical and completion of the PA by 12/31/19, I understand that I will not be eligible to enroll in this plan the following benefit plan year.**

_____ _____

PATIENT: Signature of Patient **Date of Visit**

PROVIDER

I am committed as a partner in healthcare with my patient. We have met and worked together on the date below to establish personalized goals for this next year. I will help to keep you on the path of achieving your personalized goals indicated above. This agreement is intended to be completed as part of a preventive visit with your patient. **<u>Please be sure to code this Annual Wellness Physical with one of the following CPT Codes: 99385-99387, 99395-99397 or 99401-99404.</u>**

_____ _____

PROVIDER: Signature of Provider **Date of Visit**

QUESTIONS?

Patient: Contact Member Services at 1-877-491-5511

Provider: Contact Provider Inquiry at 1-888-891-2564

PA Form can be used for Paramount Medical Home and Steps2Health programs.

LUCAS COUNTY

PARAMOUNT STEPS2HEALTH Medical Home Incentive Program