

Health Risk Assessment Form

Please answer the following questions for each member of your household:



► The attached form must be completed and returned in the enclosed envelope.

Name of the person completing this form:	
May we have your permission to contact you if we have any questions? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Member Name:	Member ID Number: <input type="text"/>
Telephone Number: <input type="text"/>	Primary Language Spoken:
1. Does this member have a Primary Care Physician (PCP) ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
a) This member had a PCP visit in the last 3 months. <input type="checkbox"/> Yes <input type="checkbox"/> No	
b) This member had a routine physical in the last 3 months. <input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Would this member like to be contacted to identify a participating doctor. <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does this member have a dentist they see regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
a) Has this member had an emergency dentist visit in the last 3 months. <input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Has this member had a scheduled routine dental exam in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Would this member like to be contacted to identify a participating dentist. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does this member use medical equipment, such as wheelchair or oxygen, in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?	
4. Has this member been hospitalized in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Has this member been to the Emergency Room (ER) 3 or more times in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. What conditions has this member been treated for or are currently being treated for: <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Substance Abuse Problems <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Transplant <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Asthma <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other Medical Problems	
7. Is this member currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following:	
a) What is the name of this member's doctor (OB)?	
b) Baby Due Date:	
8. Does this member take 4 or more medicines every day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list the medications:	

A visit to a doctor for pregnancy care should happen within 14 days of either becoming a Peach State Health Plan member or finding out you are pregnant after you join.

If you need additional copies of this form visit our website at: psph.com or contact the Member Services department at **1-800-704-1484**.