



# HEALTH RISK ASSESSMENT For Agent Use Only

## Introduction Page (Agent View):

This health risk assessment is optional. Your responses to this survey will not affect your benefits or enrollment in any way. Your results can help us determine the level of care or support you may need.

### Member Information

Member First Name: \_\_\_\_\_ Member Last Name: \_\_\_\_\_  
Medicare Beneficiary Identifier (MBI:) \_\_\_\_\_ Member State: \_\_\_\_\_

### Agent Information

Agent First Name: \_\_\_\_\_ Agent Last Name: \_\_\_\_\_  
Agent NPN: \_\_\_\_\_

### HRA Questionnaire

- Overall, how would you rate your health?  
 Great  Having problems  Poor
- Have you had your annual wellness visit with your Primary Care Provider (PCP) or a specialist in the last 12 months?  
 Yes  No  Do not have a Primary Care Provider (PCP)
- Have you had a mammogram in the last 2 years?  
 Yes  No  Does not apply
- Have you had a colonoscopy in the last 10 years?  
 Yes  No
- Are you able to walk without help?  
 Yes  Yes, but I need an assistive device (cane, rolling walker, others)  No
- Do you smoke cigarettes or use other tobacco products?  
 Yes  Quit within past 10 years  No, never smoked
- In the past 2 years, how many times have you been to the emergency room and/or had an unplanned hospitalization?  
 None  Once or twice  Three or more times
- Has your doctor or another provider ever told you that you have any of the following? (Please select all that apply)

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart failure
<input type="checkbox"/> Heart attack, coronary stents, or CABG (bypass surgery)	<input type="checkbox"/> TIA or Stroke
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Atrial fibrillation
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) or emphysema	<input type="checkbox"/> Take blood thinners
<input type="checkbox"/> Chronic liver disease (hepatitis, cirrhosis)	<input type="checkbox"/> None of the above
<input type="checkbox"/> Blood disease (anemia, low platelets, leukemia, others)	

9. Do you receive Dialysis?

Yes  No  I was told I will need it soon

10. Do you have Diabetes?

No  Yes  Yes, and my doctor said my diabetes is well controlled

11. Are you currently being treated for cancer?

Yes  No  I completed treatment within the past 3 years

12. Are you a Veteran?

Yes  No (go to question 15)

13. Do you currently receive care at a Veteran's Administration (VA) facility?

Yes  No (go to question 15)

14. At which VA Facility do you receive your care?

VA Facility Name: \_\_\_\_\_

15. Do you drive?

Yes  No  I don't drive but always have reliable transportation available

I am homebound and rarely leave the house

16. Do you do any of the following? Please select all that applies.

Text  Browse the internet on cell phone  Browse the internet on a computer and use email

17. Do you have a cell phone?

Yes  No

18. What is your cell phone number?

Cell Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

19. What is your land line?

Land Line: (\_\_\_\_)\_\_\_\_-\_\_\_\_

20. What is the best email address for us to send you health program information?

\_\_\_\_\_

Thank you, HRA is complete.

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