Partnership Agreement (PA)

MEMBER ID: _____ DATE OF AGREEMENT: _____

MEMBER NAME: _____ DOB: _____

PROVIDER NAME: _____ PROVIDER ID#: _____

This partnership agreement confirms the commitment of my provider and myself to work together to establish personal health care goals that support my health and well-being. My **PERSONAL HEALTH CARE GOALS** for this year are:

1. _____
2. _____
3. _____

My provider and I agree I should do the following:

Only select the programs that are important to be completed or participated in this year.

Enroll in a Paramount Program Check the Programs that Apply			
DISEASE MANAGEMENT PROGRAMS NOTE: THESE PROGRAMS MAY BE RECOMMENDED BY PARAMOUNT OR THE PROVIDER		**ONLINE WELLNESS PROGRAMS** ACCESS ONLINE PROGRAMS AT: WWW.PARAMOUNTHEALTHCARE.COM/PMH	
☐	Asthma – Adult/Peds	☐	Back Care
☐	Chronic Obstructive Pulmonary Disease	☐	Depression
☐	Chronic Heart Failure	☐	Diabetes Management
☐	Co-Morbid Depression	☐	Diabetes Prevention
☐	Chronic Kidney Disease	☐	Financial Wellness
☐	Diabetes – Adult/Peds	☐	Healthy Eating
☐	Migraine	☐	Heart Disease Management
☐	Osteoporosis (females 67 -85 yrs)	☐	Heart Disease Prevention
☐	Post Cardiac Event	☐	Physical Activity
☐	Reproductive Health and Wellness	☐	Quit Smoking Plan
☐		☐	Risky Drinking
☐		☐	Stress Management
☐		☐	Weight Management

Must meet with my Provider again within: No Follow-up Needed ☐ 60 days ☐ 90 days ☐ 180 days ☐

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 participate in the activities and services we agree on throughout the year, I understand I may no longer be eligible for the incentives offered by my employer.

_____ _____

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.

_____ _____

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

PROVIDER:	It is the patient's responsibility to make sure a copy of the PA is received by Paramount.
PATIENT:	Once you and your physician both sign the Partnership Agreement, YOU are responsible for sending the form to Paramount so your incentive can be earned. The best way to get the form to us is fax: **800-990-7762.** If you prefer mailing, send to: Paramount/PA INFO, PO Box 928, Toledo, OH 43697-0928.

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.

PARAMOUNT STEPS2HEALTH
Medical Home Incentive Program

PARAMOUNT MEDICAL HOME
Affiliate of ProMedica

Updated: 03/02/2017