



BlueCross BlueShield of Illinois

Practitioner Statement Regarding Diagnosis for the 2009 HMO Diabetes Flowsheet QI Fund Project

Name:	
DOB:	
Sub ID #:	

Diabetes Flowsheet Project ID Number:	
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This form is to be used if a member identified for the 2009 HMO Diabetes Flowsheet QI Fund Project does **NOT** have a diagnosis of diabetes. To be considered, the form must be completed in full including the practitioner signature and date.

Has the member been treated for any of the following conditions in 2007 or 2008?

Please check all that apply.

- Gestational diabetes
- Steroid-induced diabetes
- Polycystic ovaries and was being treated with a diabetic medication
- Other: (please specify) _____

To the best of your knowledge does the member listed above have a diagnosis of diabetes?

- Yes No

Practitioner Name: (please print) _____

Practitioner Signature: _____

Date: _____

***Note:** The statement regarding diagnoses must be signed and dated. BCBSIL will only consider forms that have been completed in full (including checking the Yes or No box). Attending MD Must Sign Form