PROVIDER MEMO

To: Santa Clara Family Health Plan Contracted Providers

From: Johanna Liu

Director, Quality & Pharmacy

Date: October 22, 2018

Subject: New Member Incentive Program – Microalbumin Urine Test for Diabetics

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Dear Provider,

Santa Clara Family Health Plan (SCFHP) is excited to announce a new Member Incentive Program to improve the completion rate of diabetes screening. Diabetic members who have not completed their microalbumin urine test will soon receive the attached letter and form about the incentive program. As our partner in health care, we value your critical role in ensuring our diabetic members receive all their required screenings.

Please assist eligible patients in qualifying for the incentive by performing a microalbumin urine test or referring them to a laboratory where they can receive their screening by December 31, 2018. No authorization request is required if they are referred to an SCFHP contracted laboratory.

SCFHP is committed to working with our contracted providers to improve the care that is provided to our diabetic members. Thank you for your continued partnership.

If you have any questions, please contact Divya Shah, Health Educator at 1-408-874-1929 or Quality@scfhp.com.

Santa Clara Family Health Plan™

PO Box 18880, San Jose, CA 95158
1.800.260.2055 | TTY 711
www.scfhp.com

[DATE]

Dear [MEMBER NAME],

When you have diabetes, it is important to work with your care team to keep it in control. Your doctor will monitor your diabetes with tests to see how it is affecting your body. These tests that monitor your diabetes are called screening tests. Work with your doctor by keeping regular check-ups and completing necessary diabetes screening tests.

Each of the following tests play a different role in keeping you healthy.

Test	**Why**	**How often**
Blood pressure	High blood pressure can cause problems to your organs (kidneys, eyes, and heart).	Each doctor visit
HbA1c blood test	Measures blood sugar levels for the past three months.	Every 3 to 6 months
Diabetes eye exam	Checks for eye problems such as cataracts, glaucoma, and retinopathy.	Once a year
Microalbumin urine test	Measures the amount of protein in your urine. It tells your doctor how well your kidneys are working.	Once a year

As a Santa Clara Family Health Plan (SCFHP) member, routine screening tests are **covered at no cost to you**.

SCFHP cares about your health! [Member Name], we noticed you have not had a Microalbumin urine test this year**. SCFHP will give you a $25 Target gift card for completing your microalbumin urine test by December 31, 2018.**

Getting the $25 gift card is simple! Complete the urine test, fill out the form and return it to SCFHP before January 31, 2019. The form **must** be signed by your doctor or lab.

If you have questions, call SCFHP Customer Service at **1-800-260-2055**. Our representatives are available 8:30 a.m. to 5:00 p.m., Monday through Friday. For TTY/TDD users, please call **1-800-735-2929** or **711**. The call is free.

Sincerely,

Jeff Robertson, MD
Chief Medical Officer
Santa Clara Family Health Plan

50241E

***Target gift card not to be used for purchase of tobacco, alcohol, or firearms.**

Santa Clara Family Health Plan

Mail the completed form

Get a $25 Target gift card*

INSTRUCTIONS:

1. **Make** an appointment with your doctor or assigned clinic and request a microalbumin urine test. Complete the test by **December 31, 2018**.

2. **Confirm** the **MEMBER INFORMATION** section below is up-to-date. If it isn't, correct it on this form.

3. **Complete** the **DOCTOR/LAB INFORMATION** section below. Have your doctor or medical assistant sign and date at your appointment.
    a. If you can't get your doctor's signature, call Customer Service at **1-800-260-2055**, 8:30 a.m. to 5:00 p.m., Monday through Friday, and ask for the Health Education Department. For TTY/TDD users, please call **1-800-735-2929** or **711**. The call is free.

4. **Mail** the completed form to SCFHP using the prepaid envelope or have your doctor fax it to **1-408-874-1959**.

SCFHP must receive the completed form with your doctor or medical assistant's signature before **January 31, 2019** to qualify for the gift card.

MEMBER INFORMATION:		
Name: «Member Full Name»		
Birth Date: «Birth_Date»	**SCFHP ID #:** «Member_ID»	
Mailing Address: «Address1» «Address2»		
City: «City»	**State:** «State»	**Zip Code:** «ZipCode»
Phone: «Phone Number»		

DOCTOR/LAB INFORMATION:
Doctor's Name:
Clinic Name:
Phone:
X

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