Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Dear Member,

We're committed to helping you and your family stay healthy. This health assessment will help us learn about your health and coordinate your care in a way that meets your personal needs.

Please take the time to answer the questions as best as you can. After you've finished the assessment, please return it to us in the self-addressed envelope enclosed.

If you lose the envelope, you can mail the completed health assessment to us at:

Anthem HealthKeepers Plus plan
Case Management
Mail Drop VA2002-N800
P.O. Box 27401
Richmond, VA 23286-8708

Have questions? We're a call away.
If you have questions about the assessment or would like to complete it over the phone, just give us a call at 1-844-533-1994, ext. 106-103-5148 Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

Thank you for being an Anthem HealthKeepers Plus member.

Sincerely,

Your Anthem HealthKeepers Plus team

Enclosures: Get help in another language
Nondiscrimination notice

www.anthem.com/vamedicaid

Health assessment

Please read each question. Please circle the answer that best describes you or the member. If the question asks you to fill in the blank, please write your answer in the space provided.

Today's date: _____

Name of person completing form: _____

Relationship to member(s) _____

Street address: _____

City: _____ State: _____ ZIP: _____

Home phone: (_____)_____

Cellphone: (_____)_____

May we send you text messages? Please circle one: Yes No

May we continue to call you on your cellphone? Please circle one: Yes No

Email address: _____

May we contact you via email? Please circle one: Yes No

What is the best phone number to reach you? Please circle one: Home Cell Other

If other, please write the number: (_____)_____

By providing us this phone number, you are giving us consent to call this phone number.

ADDITIONAL QUESTIONS ON BACK, PLEASE FLIP TO CONTINUE →

Member name	**Member DOB**	**Medicaid or FAMIS ID #**	**Anthem HealthKeepers Plus member ID #** (nine digits) ___ ___ ___ ___ ___ ___ ___ ___ ___

1. Do you have a primary care provider (PCP) who you see when you are sick or need regular checkups?

   ☐ Yes ☐ No ☐ I don't know

2. Are you seeing any specialists on a regular basis?

   ☐ Yes ☐ No ☐ I don't know

3. Have you been in the hospital within the past year, or do you have any procedures planned in the hospital in the next 60 days?

   ☐ Yes ☐ No ☐ I don't know

4. Are you taking any prescription or over-the-counter medications?

   ☐ Yes ☐ No ☐ I don't know

5. Have you been diagnosed with a behavioral health condition, or do you have a history of a behavioral health condition?

   ☐ Yes ☐ No ☐ I don't know

6. Are you receiving additional interventions such as special services through school, nursing care, day support or personal assistance?

   ☐ Yes ☐ No ☐ I don't know

7. Do you need help getting access to food, housing, transportation, health care, education/literacy, and/or employment services?

   ☐ Yes ☐ No ☐ I don't know

   7a. Please describe the needs in the space below.

8. Do you have additional health care needs such as prescription assistance, durable medical equipment, etc.?

   ☐ Yes ☐ No ☐ I don't know

   8a. Please describe the additional health care needs in the space below.

9. Have you been diagnosed with a substance use disorder or have a history of substance abuse?

   ☐ Yes ☐ No ☐ I don't know

10. Have you experienced a traumatic event(s) that currently affects you emotionally, behaviorally, and/or physically?

    ☐ Yes ☐ No ☐ I don't know

11. Are there any health care needs that have not been addressed we can help you with?

    ☐ Yes ☐ No ☐ I don't know

    11a. Please describe the health care needs in the space below.

12. For female members only: Are you pregnant?

    ☐ Yes ☐ No ☐ I don't know