

Non-SNP Medicare Health Risk Assessment (HRA)

Place a ✓ on the boxes that apply to you. The information you provide will help us tailor your care plan to your needs. The sooner we get your HRA back, the sooner we can design your care plan.

Contact Info				
First Name		Last Name		Middle Initial
Medicare ID #		Date of Birth (MM/DD/YYYY)		
Street Address				
City	State	Zip	County	

How would you rate your overall health? Poor Fair Good Excellent

In the past three months, have you gone to an emergency room for care?	<input type="checkbox"/> Yes	<input type="radio"/> No
Were you admitted to the hospital anytime within the last 6 months?	<input type="checkbox"/> Yes	<input type="radio"/> No
Have you ever been diagnosed with Diabetes or blood sugar problems?	<input type="checkbox"/> Yes	<input type="radio"/> No
Have you even been diagnosed with Coronary Artery Disease or other heart problems?	<input type="checkbox"/> Yes	<input type="radio"/> No

In the last 3 months, how many unplanned admissions to the hospital or Emergency Room for Mental Health or substance use issues have you had?	None	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> More than 2
Do you think you have a problem with alcohol or drugs?	<input type="checkbox"/> Yes	<input type="radio"/> No	
Have you fallen two or more times in the last 3 months?	<input type="checkbox"/> Yes	<input type="radio"/> No	
Do you need help with daily living skills?	<input type="checkbox"/> Yes	<input type="radio"/> No	
If Yes: Do you have the support that you need?	<input type="checkbox"/> Yes	<input type="radio"/> No	

Preferred phone #	May we text you at this number?	<input type="checkbox"/> Yes	<input type="radio"/> No
Date (MM/DD/YYYY)	What is the best time to reach you?		

Sales agent to complete this form with the member and submit via email to NONSNPHRAsubmissions@anthem.com.