

## Personal Health Covenant

This covenant outlines your Rights and Responsibilities as a member of the CoverTN Health Plan. It also identifies activities that you will undertake to improve your health, such as taking medications, keeping appointments, and avoiding unnecessary emergency room visits. We encourage you to work with your doctor and other health care providers to become healthier. If you need help finding a provider and/or scheduling an appointment, please call: 1-888-887-3224.

**Member instructions:** Please take this with you on your next visit to see the provider you have designated as your medical home. The Personal Health Covenant will serve as an agreement between you and your medical home and is your first step toward working together for your health and wellness.

### Member Rights

1. I have the right to choose my medical home. This is where I go for check-ups or when I am sick and where my health care records will be kept.
2. I have a right to make decisions about my health care. I have a right to see my medical records. I have the right to ask questions about my health care.
3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the CoverTN Health Plan.
4. I have a right to know about all laws and rules of the CoverTN Program.
5. I can contact my health plan with any questions about my health care.
6. I have a right to be sent a written notice if my eligibility is denied or limited. I have a right to appeal a decision about my eligibility.
7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

### Member Responsibilities

1. I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
2. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
3. I will go to my medical home when I am sick.
4. I will go to my medical home for well checkups.
5. I will take the medicines my health care provider prescribes for me.
6. I will arrive on time when I have my appointments.
7. I will call my medical home to let the office know if I cannot keep my appointments.
8. I will let my medical home know when there has been a change in my address or phone number.
9. I will use the hospital emergency room only for emergencies.

### Activities to improve my health include:

Please list below any activities that you will be implementing to improve your health, such as exercise, smoking cessation, and eating healthier. We encourage you to discuss and complete this section with your medical home.

I will participate in the following activity (activities) to improve my health: \_\_\_\_\_

\_\_\_\_\_

### Member Acknowledgement

The information on this paper has been explained to me and I agree to follow this Member Agreement.

\_\_\_\_\_  
Member Signature Or Responsible Party

\_\_\_\_\_  
Date

Please indicate the name of your medical home below.

\_\_\_\_\_

### Member Home Acknowledgement

I have received a copy of this Member Agreement.

\_\_\_\_\_  
Signature of Medical Home Or Representative

\_\_\_\_\_  
Date

**Provider instructions: Please place the original in the patient's chart and fax a copy to 1-866-636-0085.**



801 Pine Street  
Chattanooga, TN 37402

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association  
® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans  
This document has been classified as confidential information

CVR-009 (3/08)