Florida

Enhanced Benefit Accounts Program

List of Approved Healthy Behaviors That Allow You to Earn Credits

	Behavior Name	Enhanced Benefits Universal Form Needed?	Credit Amount Per Behavior	Behavior Limit Per Year
Children	Childhood Dental Exam	No Need*	$25.00	2
	Childhood Vision Exam	No Need*	$25.00	1
	Childhood Preventive Care (age-appropriate screenings and immunizations)	No Need*	$25.00	Any combination, up to 5
	Childhood Wellness Visit	No Need*	$25.00	
	Keep all primary care appointments	No Need*	$ 25.00	
Adults	Keep all primary care appointments	No Need*	$ 15.00	2
	Mammogram	No Need*	$25.00	1
	PAP Smear	No Need*	$25.00	1
	Colorectal Screening	No Need*	$25.00	1
	Adult Vision Exam	No Need*	$25.00	1
	Adult Dental Cleaning (Preventive Services)	Yes	$15.00	2
Additional Behaviors	Disease management participation	Yes	$25.00	1
	Alcohol and/or drug treatment program participation	Yes	$25.00	1
	Alcohol and/or drug treatment program 6 month success	Yes	$15.00	2
	"Stop Smoking" program participation	Yes	$25.00	1
	"Stop Smoking" program 6 month success	Yes	$15.00	2
	Weight loss program participation	Yes	$25.00	1
	Weight loss program 6 month success	Yes	$15.00	2
	Exercise program participation	Yes	$25.00	1
	Exercise program 6 month success	Yes	$15.00	2
	Flu Shot when recommended by physician	Yes	$25.00	1
	Compliance with prescribed maintenance medications	No Need*	$7.50	4

* No need to complete an Enhanced Benefits Universal Form, your health plan will report this activity.

Example: If you have a vision exam, you earn $25 in credits.

List of Products and Supplies Covered by the Enhanced Benefits Account Program

Antacids

Antidiarrheals

Bandages and Wound Dressings

Braces and Related Health Aids

Cough and Cold Preparations

Dental Products

Ear Drops and Wax Removal

Eye Drops

Laxatives

Multivitamins (Children and Adults)

Nose Drops

Over-the-Counter Pain Medications

Over-the-Counter Vaginal Preparations

Shampoos

Stomach Acid Reducers like Pepcid AC and Prilosec

Over-the-Counter Sunscreens

Topical Over-the-Counter Creams and Lotions

Vaporizers and Hot Water Bottles

Hearing Aid Batteries

http://ahca.myflorida.com/Medicaid/Enhanced_Benefits

Florida Medicaid Reform
Enhanced Benefits Universal Form

Instructions:

Step 1: Participate in an approved healthy behavior listed below.
Step 2: Fill in all areas of this form and sign.
Step 3: If the healthy behavior has a line under it, write the name of the behavior that has taken place.
Step 4: Have this form signed by the provider/sponsor of the healthy behavior.
Step 5: Mail or fax the completed and signed form to your health plan. See contact list on page 2.

Beneficiary's Florida Medicaid ID# _____ or **Beneficiary's Health Plan ID#** _____

Beneficiary's Last Name _____ **Date of Birth (mm/dd/yyyy)** ___/___/_____

Beneficiary's First Name _____

Beneficiary's Address _____ **City** _____ **State** ____ **Zip** _____

Healthy Behavior Participation: (*please check single behavior*) **Only one "Behavior" will be processed for each form completed.**

- ☐ Congestive Heart Failure Disease Management Program (*EB 001*)
- ☐ Diabetes Disease Management Program (*EB 002*)
- ☐ Asthma Disease Management Program (EB 003)
- ☐ HIV/AIDS Disease Management Program (EB 004)
- ☐ Hypertension Disease Management Program (EB 005)
- ☐ Other Disease Management Program (EB 006) _____
- ☐ Flu Shot (EB 007)
- ☐ Adult Dental Cleaning (preventive services) (*EB 008*)
- ☐ Alcoholic Treatment Program (*EB 009*)
- ☐ Alcoholic Treatment Program 6 Month Success (*EB 109*)
- ☐ Narcotic Treatment Program (*EB 010*)
- ☐ Narcotic Treatment Program 6 Month Success (*EB 110*)
- ☐ Smoking Cessation (*EB 011*)
- ☐ Smoking Cessation 6 Month Success (*EB 111*)
- ☐ Exercise Program (*EB 012*)
- ☐ Exercise Program 6 Month Success (*EB 112*)
- ☐ Weight Management (*EB 013*)
- ☐ Weight Management 6 Month Success (*EB 113*)

Medicaid Beneficiary Signature _____ **Date** _____

Provider/Sponsor Information

Date(s) of Participation: Start Date _____ **End Date** _____
Name _____ (*Please Print*) **Organization Name** _____
Phone # _____ **Address** _____
Signature _____ _____

Provider/Sponsor and Beneficiary Certification:

I certify that the information provided on this form is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information I can be lawfully punished for fraud. I understand that the information will be kept confidential in accordance with Florida and federal law.

For Plan Use Only

Date Received: _____ **Complete Form:** _____
Incomplete Form: _____ **Notified if Incomplete:** _____

Table 14
Enhanced Benefit Account Program Statistics

Fourth Quarter Activity		April	May	June
I.	Number of plans submitting reports by month	23 of 23	21 of 23	23 of 23
II.	Number of enrollees who received credit for healthy behaviors by month	23184	27934	22326
III.	Percentage of Reform enrollees who receive credits each month*	41.31%	47.97%	52.55%
IV.	Number of enrollees who received credit and used credits by month	2025	3103	4432
V.	Total dollar amount credited to accounts by month	$619,397.50	$787,382.50	$572,367.50
VI.	Total dollar amount of credits used by month	$44,649.98	$72,893.65	$109,975.26

* Represents the total number of beneficiaries from September 2006 thru end of month divided by total number of beneficiaries enrolled in a Reform health plan.