UT Benefits
The University of Texas System

Preventive Care Incentive Certification Form

Use this form if you meet the criteria in Section 1 or 2*
Effective May 2027 an additional **$50** premium differential applies to each employee or spouse without a preventive care exam by **February 28, 2027**. Subsequent years will require a preventive care exam.

1. If you have documentation verifying your preventive screening based on one of the following options

REASON FOR SUBMITTING PREVENTIVE CARE INCENTIVE CERTIFICATION (WITH DOCUMENTATION)
____ Preventive exam received from provider outside the US
____ Preventive exam received from the Veterans Administration
____ Coordination of Benefits with preventive exam received from another employer's insurance
____ New participant and preventive exam received prior to hire AND exam was performed SINCE February 1, 2026

OR

2. If you do <u>not</u> have documentation verifying your preventive screening due to special circumstances, your physician or healthcare provider may certify that the screening was performed. For the certification to be valid, you must complete all of Section 2.

PROVIDER INFORMATION	
PROVIDER NAME	
PROVIDER ADDRESS	CPT CODES (SEE LIST BELOW)
DESCRIPTION OF SERVICE	DATE OF PREVENTIVE CARE EXAM

TYPICAL CPT CODES	
Routine preventive physical exam in office setting	**99381–99387** (new patients); **99391–99397** (established patients)
Preventive physical exam in outpatient setting	**99381–99387, 99391–99397**
Preventive physical exam at retail clinic	**99381–99387, 99391–99397**
Preventive well-woman exam	**99384-99387** (new patients) **and 99394–99397** (established patients), depending on age

3. Employee and provider information

SUBSCRIBER / DEPENDENT SPOUSE INFORMATION	
EMPLOYEE NAME (LAST, FIRST, MIDDLE)	**BENEFITS ID** (BID)
NAME OF SPOUSE (LAST, FIRST, MIDDLE)	**PATIENT DATE OF BIRTH**

ALTERNATIVE PROVIDER CERTIFICATION	
PROVIDER NAME (PRINTED)	
PROVIDER ADDRESS	**CPT CODES** (SEE LIST ABOVE)
DESCRIPTION OF SERVICE	**DATE OF PREVENTIVE CARE EXAM**

4. Provider and employee signature and submission instructions

PROVIDER CERTIFICATION SIGNATURE	
By submitting this form, I certify that the person named is my patient and has received a Preventive Exam as indicated by the procedure code provided.	
Provider Signature	**Date**

EMPLOYEE SIGNATURE	
Employee Signature	**Date**

SUBMISSION INSTRUCTIONS

Email the completed PCIP form, along with the explanation of benefits or other supporting itemized documentation showing the preventive exam, to:

Blue Cross and Blue Shield of Texas

UTS_PCIPcertificationform@bcbstx.com

***Please note:** If you are enrolled in UT SELECT medical coverage as an active employee and choose to visit a non-BCBSTX provider who is out of network, use the BCBSTX Claim Form at **https://www.bcbstx.com/docs/forms/claim/tx/medical-claim-tx.pdf** or contact a **UT SELECT Concierge** directly for assistance: **866-882-2034**.

Legal notices relating to the plan are available at **Legal Notices | The University of Texas System**.