

## ELECTRONIC SHA FORMAT NOTIFICATION FORM

E-mail your completed request form to  
[BlueShieldofCAHealthEducation@blueshieldca.com](mailto:BlueShieldofCAHealthEducation@blueshieldca.com) or fax to 323-889-5407.

Clinic/Organization Name:		
Provider's First Name:		Provider's Last Name:
Street Address:		
City:		Zip Code:
Phone No:	Fax No:	Email:
<b>ELECTRONIC SHA FORMAT NOTIFICATION</b>		
Today's date:		
1. Expected date of implementation (must be at least two months after today's date):		
2. Check the age groups the electronic SHA format will be used for:		<input type="checkbox"/> All age groups <input type="checkbox"/> 5-8 years <input type="checkbox"/> 0-6 months <input type="checkbox"/> 9-11 years <input type="checkbox"/> 7-12 months <input type="checkbox"/> 12-17 years <input type="checkbox"/> 1-2 years <input type="checkbox"/> Adult <input type="checkbox"/> 3-4 years <input type="checkbox"/> Senior
3. Indicate how you will be implementing the electronic SHA format:		<input type="checkbox"/> Add the exact SHA questions into an electronic medical record <input type="checkbox"/> Scan the SHA to use it as an electronic medical record <input type="checkbox"/> Use the SHA in different electronic or paper-based format
4. Electronic SHA format must include a way for the provider to document a signature. Describe how you will be documenting this on your system:		
5. Electronic SHA format must include all updated SHA questions and questions should not be altered from their original form. Will your electronic format follow these rules?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SIGNATURE</b>		
Provider Signature:		Date:
<b>HEALTH PLAN USE ONLY</b>		
Approver Signature:		Date:

If you have questions, please email [BlueShieldofCAHealthEducation@blueshieldca.com](mailto:BlueShieldofCAHealthEducation@blueshieldca.com) or call 323-827-6036.