Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

State of Iowa

Health Care Provider Biometric Screening Form

INSTRUCTIONS

- **PARTICIPANT** - complete section 1
- **HEALTH CARE PROVIDER** - complete section 2

SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed

Participant's Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Gender: M F

Participant's First Name | MI | Participant's Last Name

Address | Unit/Apt

City | State | Zip Code

Email Address

Phone Number ___ - ___ - ____

Do you smoke: Yes No

Are you: Employee Spouse

Please read the following disclosure statement. I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information willl not be shared with my Employer: however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer-sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

I hereby consent and authorize Summit Health to release and share my test results and reports to WebMD Health Services Group, Inc. ("WebMD"), and I agree that the WebMD Privacy Policy that I accepted, or shall accept, upon my registration, describes how WebMD will use my health information.

Participant's Signature: _____ Date: ___ (Month) ___ (Day) ____ (Year)

PATIENTS: Biometric Screening must be completed on or after (9/1/2014) to receive completion credit or incentive (if applicable). This form must also be completed in its entirety, accurately and legibile in order to be deemed complete.

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - for physician or office staff use only below this line

FOR HEALTH CARE PROVIDER: ***State of Iowa*** is offering a voluntary wellness program to encourage participants to understand their health risk.

Height: ___ ft ___ in

Weight: ___ lbs

Blood Pressure: ___ Systolic ___ Diastolic

Blood Panel

Total Cholesterol: ___ **HDL:** ___ **TC/HDL ratio:** ___

Triglycerides: ___ **LDL:** ___ **Glucose:** ___

Fasting Status (Check one): ___ Fasting ___ Non-Fasting

___ I certify the listed biometric values are correct

Facility Name: _____

Phone Number: _____ Date of Service/Test: _____

Health Care Provider's Name: _____

Signature: _____ Date: _____

Please fax completed form to Summit Health at (248) 864-4409 by Deadline 6/30/2015

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid

Date Faxed: _____