NJWELL Physician Biometric Health Screening Form Instructions

Thank you for choosing to participate in NJWELL's 2014 Biometric Screening Program. Please use this form if you are going to receive health screening services from your personal physician. Summit Health is the Biometric Health Screening vendor for NJWELL. Instructions for completing the health screening form are detailed below.

PLEASE NOTE: This form must be completed in its entirety. Any forms submitted with missing information will be rejected and wellness points for the health screening will not be awarded.

Step 1:
Make an appointment with your physician and request a full lipid panel, blood pressure reading, height and weight measurement, and body mass index.

Step 2:
Read page 2 and complete the Physician Biometric Health Screening Form in its entirety. **BOTH** participant and physician must sign. Forms will **NOT** be accepted without both parties' signatures.

Step 3:
There are two (2) options for sending in your results to Summit Health. Either you or your physician can:

1. Fax results to ATTN: Data Integrity Group at 248-864-4409
2. Mail results to:

   Summit Health
   ATTN: Data Integrity Group
   27175 Haggerty Road
   Novi, MI 48377

PLEASE RETAIN A COPY FOR YOUR RECORDS ALONG WITH THE FAX CONFIRMATION, if applicable. Completed forms mailed or faxed to Summit Health must be received by October 31, 2014.

Summit Health complies with all HIPAA Privacy and Security Standards, and maintains the confidentiality of all information relating to employees that choose to participate – which means that individual results are never released unless the appropriate written consent is provided by the SHBP/SEHBP member. A high-level summary of the aggregate results will be provided to the NJWELL Coordinator(s) to better understand the impact their efforts are having on the overall health and well-being of the SHBP/SEHBP members. This information will assist in customizing future programs which will promote the specific health/prevention needs of the SHBP/SEHBP members.

All results must be received by Summit Health no later than 10/31/14. DO NOT send any biometric results to NJWELL or your health plan.

Screening and Informed Consent/Authorization Release Form

1. I agree to participate voluntarily in this health screening activity coordinated by NJWELL and Summit Health. The health screening includes:
   - Blood test to include:
     - Total Cholesterol (TC)
     - HDL
     - TC/HDL ratio
     - Glucose values
   - Blood Pressure Reading
   - Pulse Reading
   - Body Mass Index (BMI)
2. I hereby release Summit Health and/or their agents and staff from any and all liability arising from or in any way connected with my health screening.
3. I understand it is my responsibility to 1) direct questions regarding testing to those administering the tests and 2) follow-up with my physician to discuss the results of these tests when so advised.
4. I understand that any information collected as part of this health screening will be treated as confidential. Individual health information will not be shared with my employer.
5. I understand that my individual health data will be used by Summit Health to:
   - Evaluate the impact of the wellness program.
   - Provide my employer aggregate information as part of a group summary report (my individual data will not be disclosed).

   I authorize my physician or lab to perform the above listed tests and release information regarding these tests to Summit Health.
   The results and a copy of the release form can be faxed directly to the Data Integrity Group at Summit Health at 248-864-4409.

6. I understand that receipt of my fully completed Physician Biometric Health Screening Form will be reported to the Health Plan / Reward Administrator within 14 to 21 days of receipt via fax or mail and that I can verify that the form has been received by viewing the Health Plan's website Rewards page.

By signing the Physician Biometric Health Screening Form, I agree to the terms outlined above.

NJWELL
Working for a Healthy New Jersey

NJWELL
Physician Biometric Health 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.

PLEASE PROVIDE YOUR FULL NAME:

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

Participant's Date of Birth (MM/DD/YYYY) / / | Gender M F

REQUIRED: Please select ONE of the following boxes:

☐ **I am a Horizon BCBSNJ Member** ☐ **I am an AETNA Member**

REQUIRED: Based on your answer above, please enter your corresponding Member ID below:

Horizon Member ID (Fill numbers only, omitting the 3 H Z N)

Aetna Member ID

Address | Unit/Apt

City | State | Zip Code

Email Address

Phone Number – –

Do you smoke or use smokeless tobacco products: ☐ Yes ☐ No

Are you: ☐ Employee ☐ Spouse/ Partner

Please read the following disclosure statement. I understand that my health screening data will be released to health plans associated with NJWELL 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/NJWELL, however my Employer/NJWELL may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer/NJWELL. In addition, if my Employer/NJWELL 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/NJWELL or Employer/NJWELL 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.

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

PATIENTS: Date of screening must be between 11/1/2013 - 10/31/2014 to receive completion credit or incentive (if applicable).

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

FOR HEALTH CARE PROVIDER: NJWELL is offering a voluntary wellness program to encourage participants to understand their health risks.

FIELDS WITH AN ASTERISK ARE REQUIRED FOR THE FORM TO BE PROCESSED.

Height ft in | **Weight** lbs | **Body Composition** Waist, Hip, *BMI, Body % Fat | ***Blood Pressure** Systolic, Diastolic

Blood Panel

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

Triglycerides: | LDL: | *Glucose:

Fasting Status (Check one) ☐ Fasting ☐ Non-Fasting

Pulse

☐ I certify the listed biometric values are correct

Facility Name: _____

Phone Number: _____

*Health Care Provider's Name: _____

*Health Care Provider's Signature: _____

*Date of Service/Test: _____

*Date: _____

*Date Faxed: _____

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid. ALL FORMS MUST BE SUBMITTED TO SUMMIT HEALTH BY 10/31/14 .

Please fax completed form to Summit Health at (248) 864-4409. PLEASE RETAIN A COPY FOR YOUR RECORDS ALONG WITH THE FAX CONFIRMATION, if applicable.

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