

WPS HEALTH INSURANCE ALTERNATIVE MEANS SCREENING (AMS) PROCESS

All State of Wisconsin employees, annuitants, spouses and dependents over 18 insured by WPS Health Insurance may use the “Alternative Means Screening Process” option provided by HealthFitness, our third party Health Management partner. We encourage you to take advantage of opportunity to learn more about your current health status.

Please follow the instructions below to participate in your screening:

1. Call your medical health care provider for an appointment.*
2. Attend your appointment and make sure that you have the following measurements completed. For the most accurate results, you are encouraged to fast, which means consuming nothing but water, for 9-12 hours prior to your appointment. Please take all of your regular prescriptions as directed by your medical health care provider.

- Height
- Weight
- Blood Pressure
- Total Cholesterol
- LDL Cholesterol
- HDL Cholesterol
- Triglycerides
- Glucose

3. Ask your medical health care provider to complete the “Authorization to Release Biometric Screening Information” form (page 2).
4. Review your form carefully before submitting, as HealthFitness will process only those forms that have been fully completed.
5. Return your completed “Authorization to Release Biometric Screening Information” form via fax or mail to arrive to **Health Fitness Corporation** at:

Fax Number: 1-866-698-9924

**HealthFitness Corporation
18325 Waterview Parkway, Suite B200
Dallas, TX 75252**

Please remember to keep a copy of the form as confirmation for your records. Check the website two to three weeks after you’ve submitted your screening data to view your results that will be merged with your health assessment.

We hope that you take advantage of this great benefit. If you have any questions about this process, please contact HealthFitness Customer Service 888-772-7734, option 1. Remember in order to qualify for your incentive you still need to take a Health Risk Assessment questionnaire online at www.portal.hfit.com/wpsetf.

** All State of Wisconsin employees, annuitants, spouses, and dependents over 18 insured by WPS who completed a health screening/blood work with their medical care provider can have their provider complete the “Authorization to Release Biometric Screening Information” form and then fax or mail it in to HealthFitness - no additional screening is required. Please be aware that the program does not pay the cost for your office visit or any fees your medical care provider may charge to fill out the form.*

To participate in the **WPS Health Insurance** Alternative Screening program, you and your health care provider must complete this entire form. If any items are left blank or unsigned by your health care provider, this form will be considered incomplete.

Please fax your completed form to **Health Fitness Corporation (HealthFitness)** at 1-866-698-9924 or mail to 18325 Waterview Parkway, Suite B200, Dallas, TX 75252. Please remember to keep a copy of this form as confirmation for your records.

PARTICIPANT INFORMATION: PARTICIPANT MUST COMPLETE THE INFORMATION BELOW

Member ID:		Full Name:	
Date of Birth:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Preferred Telephone Number:		Email Address:	n/a

BY SUBMITTING THIS FORM TO HEALTHFITNESS (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:

HealthFitness treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Generate a personalized health report for you.
- Generate a summary report so that your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at HealthFitness' sole discretion):

- Authorized HealthFitness employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer's health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information;
- Those with whom we are required to share your information by applicable law, court orders or government regulations; or
- Health care personnel for treatment purposes including, for example, emergency assistance personnel.

MEDICAL FACILITY INFORMATION: PARTICIPANT MUST COMPLETE AND SIGN THE INFORMATION BELOW

I hereby authorize the medical facility listed below to release biometric assessment data to HealthFitness.

Facility Name:		Telephone Number:	
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Participant Signature: _____ **Date:** _____

BIOMETRIC ASSESSMENT: MEDICAL HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW

Was your patient fasting? This means s/he have NOT had anything to eat or drink other than water in the last 9-12 hours.
 Note: *If s/he has not fasted, s/he may still participate, however, some of the measurements may be affected.*

Yes No

Height:	<input type="text" value="inches"/>	Weight:	<input type="text" value="pounds"/>	Waist:	<input type="text"/>	Total Cholesterol:	<input type="text"/>
HDL:	<input type="text"/>	LDL:	<input type="text"/>	Triglycerides:	<input type="text"/>	Glucose:	<input type="text"/>
Blood Pressure:	<input type="text"/>						

Medical Health Care Provider Name (Please Print): _____

Medical Health Care Provider Signature: _____ Date: _____