

**State of Wisconsin**

## **Biometric Screening Results**

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The Security Health Plan member presenting this form is participating in a worksite wellness program through the State of Wisconsin Group Health Insurance Program that requires an annual biometric screening as part of a voluntary wellness program. Fax the completed form to Security Health Plan at 715.221.9283 by December 13, 2016. Results must be submitted by the provider. Self-reporting results by the member will not be accepted.

### **Member instructions**

- Complete **Section 1: Member Information** and include your signature before meeting with your provider. Provide this form to your provider at your scheduled office visit. When scheduling your exam, notify the appointment coordinator of your need for a biometric screening.
- Coverage for biometric screenings is based on guidelines listed in the Affordable Care Act (ACA). You will be responsible for any copay or coinsurance for biometric screenings not covered under the ACA guidelines. You will also be responsible for out-of-pocket expenses for additional tests or consultation that occurs beyond what is covered under your preventive benefit. Contact Security Health Plan Customer Service if you have questions about benefits at 1.800.472.2363.
- Discuss your results and any risk factors with your provider. Ask your provider whether there are any additional age- or gender-specific preventive services that should be completed (e.g. mammogram or colorectal exams).

### **Provider instructions**

- Complete **Section 2: Provider Information** and **Section 3: Measures and Test Results** of the form. Fax only the completed results form to Security Health Plan at 715.221.9283 (this is a specific fax number for this employer group) by December 13, 2016. Incomplete or late submissions of this form might delay or eliminate your patient from program incentives. Laboratory reports should not be faxed. Only data entered on this form will be accepted.

**Section 1: Member Information (please print clearly)**

Subscriber number (found on your Security Health Plan membership card)		Group name <b>State of Wisconsin</b>	
Last name (print)		First name	MI
Email (optional)			Date of birth

**Release and use of information consent**

I authorize my provider to disclose the health information described on this form to Security Health Plan. I further authorize Security Health Plan to disclose such information to WebMD. The purpose of these disclosures is to verify the biometric test results required as part of my employer group's worksite wellness program and to post my results to my personal health assessment, which is maintained by WebMD. This authorization will remain in effect for 3 months or until I am no longer covered by Security Health Plan, unless I revoke this authorization in writing (at any time) as described by the Security Health Plan Notice of Privacy Practices (copy available upon request). I understand Security Health Plan will not condition my enrollment or eligibility for benefits on providing this authorization. I understand Security Health Plan, WebMD will not voluntarily disclose my personal health information to my employer or any other third party without my specific authorization or as permitted by law.

Member signature \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_|\_\_\_\_|\_\_\_\_

**Section 2: Provider Information (please print clearly)**

The Security Health Plan member presenting this form is voluntarily participating in a worksite wellness program through the State of Wisconsin Group Health Insurance Program that includes an annual biometric screening. Please complete the following screenings based upon your clinical practice guidelines and the U.S. Preventive Services Task Force (USPSTF) recommendations, and fax the form to Security Health Plan.

Provider/Clinic name	Phone number
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Provider signature \_\_\_\_\_ Date (mm/dd/yy) \_\_\_\_|\_\_\_\_|\_\_\_\_

**Section 3: Measures and Test Results (please print clearly)**

Screening date (mm/dd/yy) ____ ____ ____		Fasting (8 – 12 hours): <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Height ____ ____. ____ ____ in.	Weight ____ ____ ____ lbs.	Body mass index ____ ____. ____ ____	Waist measurement ____ ____. ____ ____ in.	Blood pressure ____ ____/____ ____	
LDL cholesterol ____ ____ mg/dL	HDL cholesterol ____ ____ mg/dL	Total cholesterol ____ ____ mg/dL	Glucose ____ ____ mg/dL	Triglycerides ____ ____ mg/dL	

Fax completed form to **715.221.9283** by **December 13, 2016**.