

# WELL WISCONSIN

## WELLNESS VISIT VERIFICATION FORM

### For participants of the State of Wisconsin Group Health Insurance Program

This form is for use by eligible employees and spouses/domestic partners who are unable to participate in a Well Wisconsin workplace screening. By completing this form and submitting to UnitedHealthcare, you will have met the 1<sup>st</sup> requirement of the Well Wisconsin program. Please use this information to complete step 2, by logging into myuhc.com and completing the Rally Health Assessment survey.

### For the Member to complete:

Patient Name:	
Patient Mailing Address:	
Subscriber Name:	Subscriber ID # (See ID Card):
<p><b>Please select one of the options below:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <b>I attest that, I/the above named patient, is not due for the listed screenings at this time based on the current USPSTF guidelines.</b> Your practitioner may report prior results if your age and risk factors do not indicate the need for an updated screening. You may use those results to complete the survey. Please have your practitioner sign and date this form in the physician section on back side.</li><li><input type="checkbox"/> <b>I have recently had my biometric taken by my practitioner.</b> Please have your practitioner complete the biometric screening information section on back (or attached a copy of results to this form). <b>Note:</b> <i>Your visit to your physician to obtain these results may be subject to deductible, copayment, or co-insurance depending on how the visit is billed to UnitedHealthcare. Please discuss with your physician what is recommended for you.</i></li><li><input type="checkbox"/> <b>I am currently pregnant</b> – you will not need to complete the biometric screening. Just have your practitioner sign and date this form in the physician section on the back side.</li></ul>	
Patient Signature:	Date:

Patient Name: \_\_\_\_\_

**For the Provider office to complete:**

Screening Test	Results	Date of test
Height		
Weight		
Blood Pressure		
Total Cholesterol *		
LDL Cholesterol*		
HDL Cholesterol*		
Triglycerides*		
Glucose *		
<b>Name of Practitioner:</b>		
<b>Signature of Practitioner:</b>		<b>Date:</b>

**Special Instructions:**

**Please send completed form to:**

UnitedHealthcare of Wisconsin  
Attn: Shelly– Field Account Manager  
PO Box 13187  
Green Bay, WI 54307

Or Fax to: 866-674-5637

- Employers are required to report health plan incentives issued to the employee and their spouses/domestic partners as taxable income. UnitedHealthcare is required to report incentive payments to your employer. Health information is protected by federal privacy and will not be shared with your employer.
- It is the member's responsibility to ensure that the fax or form mailed is completed and submitted by December 31.

*\*Consult your physician to determine if current results for these tests are needed for your age and gender according to the U.S. Preventive Services Taskforce Guidelines. If appropriate, your physician may report results from a prior year.*