

2016 Wellness Assessment Exception Form



This form should be completed to report your biometric measurements to Unity Health Insurance when you do not receive your biometric measurements at a workplace Well Wisconsin sponsored screening event. To learn more about the Well Wisconsin program visit www.wellwisconsin.wi.gov. Labs conducted outside of the federal guidelines for preventive services or for diagnostic purposes other than participation in the Well Wisconsin program may be subject to member cost share in the form of deductibles and / or coinsurance.

STEP 1: YOUR INFORMATION (Required)

Last Name _____ MI _____ First _____ Date of Birth (mm/dd/yyyy) _____
 Phone _____ Email _____
 Female Male Subscriber # _____
(This is the nine digit subscriber number and two digit person code found on your ID card.) Employer Name _____

STEP 2: REASON FOR THE EXCEPTION (Check One Box Below)

Select one option below and complete the information required for that exception.

I am pregnant—Have your practitioner complete the Practitioner Information (Section A) **Or** Have your employer complete the Employer Information (Section B)

I have had my biometric measurements taken by my practitioner within the current calendar year—Have your practitioner complete the Biometric Measurement Information (Section C) and the Practitioner Information (Section A) **Or** Attach a copy of all of the verified biometric measurement information requested in Section C, including your name and the date of service, to this form. *(Please Note: Biometric measurements printed from MyChart, a different online medical record or on letterhead from your clinic are acceptable. Forms that do not include all of the required biometric measurements will be returned for completion.)*

I attest my biometric measurements are within acceptable medical guidelines per my practitioner and do not need to be re-measured this year. (Measurements need to have been completed within timeframes established by U.S. Preventive Services Task Force guidelines. Height, weight, and blood pressure need to be measured annually.) Sign your name below to attest and attach a copy of all of the verified biometric measurement information requested in Section C, including your name and date of service to this form. *(Please Note: Biometric measurements printed from MyChart, a different online medical record or on letterhead from your clinic are acceptable. Forms that do not include all of the required biometric measurements will be returned to you for completion.)* **Or** Sign your name below to attest and have your practitioner complete the Biometric Measurement Information (Section C) and the Practitioner Information (Section A)

Member's Signature: _____ Date: _____

SECTION A: PRACTITIONER INFORMATION

Name of Clinic / Practitioner (please print) _____

Practitioner's Signature _____ Today's Date _____

SECTION B: EMPLOYER INFORMATION

State Agency or Local Government Employer Name (please print) _____

Employer's Signature _____ Today's Date _____

SECTION C: BIOMETRIC MEASUREMENT INFORMATION (Complete All Fields Below)

Screening Test	Result	Date of Result	Please Check the Correct Box Below Based on the Test
Total Cholesterol			<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting
LDL Cholesterol (only required if fasting)			<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting
HDL Cholesterol			<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting
Triglycerides (only required if fasting)			<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting
Glucose			<input type="checkbox"/> Fasting <input type="checkbox"/> Non-Fasting
Blood Pressure			
Height (needed to calculate BMI)			
Weight	lbs		

STEP 3: SEND YOUR COMPLETED FORM AND ANY DOCUMENTATION (IF APPLICABLE) TO UNITY

Unity Health Insurance Attn: Health Screening, Biometrics 840 Carolina Street Sauk City, WI 53583	Fax: (608) 643-2564 Call: (800) 362-3310	FOR OFFICE USE ONLY: Date entered: _____ Data entered by: _____ Date audited: _____ Data audited by: _____
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