



2016 State of Wisconsin Group Health Insurance Program Biometric Screening Form Overview

The fax form on page two is for use by eligible employees and spouses/domestic partners who are unable to participate in a Well Wisconsin workplace screening. The completed form fulfills one of two requirements of the Well Wisconsin Program. The second requirement is completion of the health assessment located at www.trustinyourhealth.com. **Both requirements must be completed by December 31, 2016 to qualify for the incentive.**

Employers are required to report health plan incentives issued to the employee and their spouses/domestic partners as taxable income. The WEA Trust is required to report incentive payments to your employer. Health information is protected by federal privacy laws and will not be shared with your employer.

2016 Well Wisconsin Overview

Eligible employees and their spouses/domestic partners who have WEA Trust health insurance can participate in a Well Wisconsin workplace screening OR their physician can collect and submit verifiable biometric values.

- To locate a Well Wisconsin workplace screening go to www.wellwisconsin.wi.gov.
- Your physician must provide the following measures:
 - Height
 - Weight
 - Body mass index (BMI)
 - Blood Pressure
 - Total Cholesterol and Blood Glucose—Consult your physician to determine if these two tests are needed for your age and gender according to the U.S. Preventive Services Taskforce Guidelines. Your physician can write “not needed” or submit the most recent lab values and the date obtained for these two tests. Self-reported measures will not be accepted.
- It is the member’s responsibility to ensure the fax form is complete and submitted by 12/31/16. Click www.weatrust.com/contactus to contact WEA Trust’s customer service through our secure online process or call us at 800.279.4000 or 608.276.4000.
- Your medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). Participation in the wellness program is voluntary. ***Your visit to your physician to obtain your biometric data may be subject to deductible, co-payment, or co-insurance charges depending on how the visit is billed to WEA Trust. Please discuss with your physician.***

Instructions for a State Health Plan participant with WEA Trust health insurance:

1. Complete Section 1 of the *Biometric Screening Form*, sign it, and date the form.
2. Ask your physician to complete Section 2 of the form, sign it, and fax the form directly to WEA Trust at 608.276.9119.
3. All fax forms must be complete and received at WEA Trust by December 31, 2016, to qualify.

**2016 State of Wisconsin Group Health Insurance Program
Fax to WEA Trust Insurance at 608.276.9119**

Well 200 SHP
(office use only)

Dear Physician:

I am participating in the Wisconsin State Health Plan's Well Wisconsin Wellness Program. As a requirement of this plan, I have agreed to complete a biometric screening. Please complete **Section 2** below and fax the completed and signed form to WEA Trust by **December 31, 2016**.

SECTION 1: Patient Information. (Patient completes and signs this section.)		
WEA Trust Member ID:	Date of Birth:	Gender: Male Female
First Name:	Last Name:	
Street Address:		
City:	State:	Zip Code:
Telephone Number:	Email Address:	

Please read the following disclosure statement: I understand that my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge that I am voluntarily participating in this health screening. *Your visit to your physician to obtain this data may be subject to deductible, co-payment, or co-insurance depending on how the visit is billed to WEA Trust. Please discuss with your physician.*

Patient Signature: _____ **Date:** _____

SECTION 2: PATIENT BIOMETRIC VALUES. (Physician completes and signs this section.)		
Date of Exam:		
Height	feet	inches
Weight	pounds	
Body Mass Index		
Blood Pressure	Systolic _____ mmHg Diastolic _____ mmHg	
	Is patient on medication for hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Total Cholesterol (per USPSTF guidelines)	_____ mg/dl Circle one: Fasting Non-Fasting	
	Is patient on medication for lipid management? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Glucose (per USPSTF guidelines)	_____ mg/dl Circle one: Fasting Non-Fasting	
	Is patient on medication for glucose management? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician Name:	Phone Number ()	
Street Address	Fax Number ()	
City:	State:	Zip Code:

Physician's Signature (required): _____ **Date:** _____