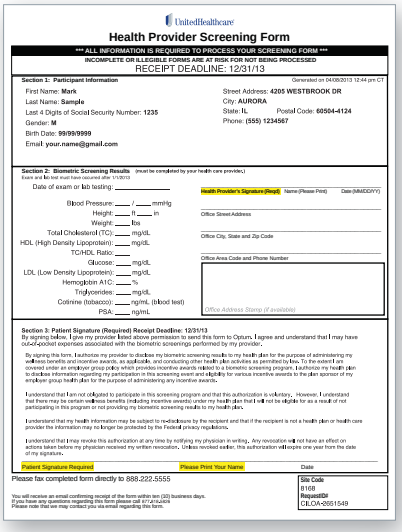
# Know Your Numbers.

**Health Provider Screening Form**

## Don't leave good health to chance.

Knowing your important health numbers (like blood pressure and cholesterol) may help keep little health issues from growing into big ones. The **Health Provider Screening Form** allows you to complete your screening at your own provider's office.



UnitedHealthcare

**Health Provider Screening Form**

*** ALL INFORMATION IS REQUIRED TO PROCESS YOUR SCREENING FORM ***
INCOMPLETE OR ILLEGIBLE FORMS ARE AT RISK FOR NOT BEING PROCESSED
RECEIPT DEADLINE: 12/31/13

**Section 1: Participant Information** Generated on 04/08/2013 12:44 pm CT

First Name: **Mark**
Last Name: **Sample**
Last 4 Digits of Social Security Number: **1235**
Gender: **M**
Birth Date: **99/99/9999**
Email: **your.name@gmail.com**
Street Address: **4205 WESTBROOK DR**
City: **AURORA**
State: **IL** Postal Code: **60504-4124**
Phone: **(555) 1234567**

**Section 2: Biometric Screening Results** (must be completed by your health care provider.)
Exam and **lab** test must have occurred after 1/1/2013

Date of exam or lab testing: _____
Blood Pressure: ___ / ___ mmHg
Height: ___ ft ___ in
Weight: ___ lbs
Total Cholesterol (TC): ___ mg/dL
HDL (High Density Lipoprotein): ___ mg/dL
TC/HDL Ratio: ___
Glucose: ___ mg/dL
LDL (Low Density Lipoprotein): ___ mg/dL
Hemoglobin A1C: ___ %
Triglycerides: ___ mg/dL
Cotinine (tobacco): ___ ng/mL (blood test)
PSA: ___ ng/mL

Health Provider's Signature (Req'd) Name (Please Print) Date (MM/DD/YY)
Office Street Address
Office City, State and Zip Code
Office Area Code and Phone Number
Office Address Stamp (if available)

**Section 3: Patient Signature (Required) Receipt Deadline: 12/31/13**
By signing below, I give my provider listed above permission to send this form to Optum. I agree and understand that I may have out-of-pocket expenses associated with the biometric screenings performed by my provider.

By signing this form, I authorize my provider to disclose my biometric screening results to my health plan for the purpose of administering my wellness benefits and incentive awards, as applicable, and conducting other health plan activities as permitted by law. To the extent I am covered under an employer group policy which provides incentive awards related to a biometric screening program, I authorize my health plan to disclose information regarding my participation in this screening event and eligibility for various incentive awards to the plan sponsor of my employer group health plan for the purpose of administering any incentive awards.

I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. However, I understand that there may be certain wellness benefits (including incentive awards) under my health plan that I will not be eligible for as a result of not participating in this program or not providing my biometric screening results to my health plan.

I understand that my health information may be subject to re-disclosure by the recipient and that if the recipient is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation. Unless revoked earlier, this authorization will expire one year from the date of my signature.

Patient Signature Required | Please Print Your Name | Date

Please fax completed form directly to 888.222.5555

Site Code
9168
RequestID#
CLOA-2851549

You will receive an email confirming receipt of the form within ten (10) business days.
If you have any questions regarding this form please call 877.816.8404
Please note that we may contact you via email regarding this form.

### The process is simple …

1. Visit the web site below and download the screening form.
2. Take the form with you to your appointment.
3. Your provider records the screening results.
4. Either you or your provider returns the form to UnitedHealthcare by fax (instructions are provided on the form).

For more information and to download your form today, visit

**https://register.wellness-inc.com/kllm**

UnitedHealthcare®

This program is administered by Optum, a health and well-being company that provides information and support as part of your health plan. Participation in the program is strictly voluntary and is not a substitute for your doctor's care. This program and your screening results are provided for informational purposes only and are not intended to diagnose problems or provide specific treatment recommendations. Your screening results will be kept confidential in accordance with the law, and with your consent, will be shared with your health plan for administration of your wellness programing and other health plan activities.

By signing the form, you give your provider permission to send the form to UnitedHealthcare. You may have out-of-pocket expenses associated with the biometric screenings performed by your provider.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc., or their affiliates.