Physician Screening Form Instructions

Important Steps

1. **Print the entire document.** This document includes:
   - Physician Screening Form Instructions
   - Screening Results Page
   - *Health Support Program Notice and Consent*
2. **Do not photocopy this document.**
   If a photocopy of the form is submitted, it will not be processed.

Completion Instructions for Participant:

Complete the *Participant Information* section of the *Screening Results Page*. Print legibly using a black pen and ensure that you have completed all fields in this section. **Note:** If information is incomplete or illegible, your form will not be processed.

1. **Participant Information**
   Complete all fields in the Participant Information section and read the Health Support Program Notice and Consent. Sign and date the *Screening Results Page* in the areas provided. **Note:** If your signature is not on the *Health Support Program Notice* and *Consent page*, your application will not be processed.

Completion Instructions for Physician:

Complete all requested items in the sections labeled as *Biometric Measurements* and *Physician Information*.

1. **Biometric Measurements**
   Provide the numeric value of member's biometric measurements and blood test. The results must be collected between 7/1/12 and 6/30/13. Standard methods to obtain the biometric measurements are described on the form. **If a new blood test needs to be completed to obtain the values, please update this form once the results are received.*

2. **Physician Information**
   Complete this section, sign and date the form in the areas provided. **Note:** Without *physician signature* the form will not be processed.

Submission instructions:

Once the all sections of the form have been completed, follow the instructions below to ensure receipt of your *Physician Form* for processing.

1. **Ensure all fields are completed on the Form**
   Once all items are completed on the form, make a copy for your records.

1. **Return completed "Screening Results Page" by mail or fax**
   Digital Documents
   P.O. Box 860846
   Shawnee, KS 66286-9907

   Fax: 615-349-2342
   *Please print fax confirmation notification & retain for your records

Must be postmarked no later than June 30, 2013 to receive incentive

Note: If you have any questions regarding the process, please contact Healthways Customer Support at (866) 556-2288

HEALTHWAYS

S T O H
LAB CODE

Screening Results Page

For optimal accuracy, please write your responses in PRINTED CAPITAL LETTERS without touching the sides of the boxes.

PARTICIPANT COMPLETE YELLOW AREA

Participant Information

PARTICIPANT COMPLETE YELLOW AREA

Last Name

Date of Birth / /

First Name

Gender ○ M ○ F

EMPLOYEE ID NUMBER

Preferred Phone Number - -

Ext.

Preferred E-mail Address

Fold here

Medical History: Select any conditions you have or have had:

○ Heart Disease ○ High Cholesterol ○ High Blood Pressure ○ Diabetes

I, the above named participant, have read, understand and agree to the terms on the Wellness Notice and Consent on the reverse side of this form. No attempts by the participant to modify or amend this form will change such terms or in any way be binding upon Healthways.

Signed

Date / /

PHYSICIAN COMPLETE BLUE AREA

Biometric Measurements

PHYSICIAN COMPLETE BLUE AREA

Height (Obtained without shoes, measured to the nearest ¼ inch)

ft in.

○ 1/4 ○ 1/2 ○ 3/4 ○ even

circle one above

Total Cholesterol mg/dL

Triglycerides mg/dL

Weight without shoes) lbs

HDL mg/dL

Fasting Glucose mg/dL

Waist (Measured at the navel. Round down to the nearest inch) in.

LDL mg/dL

Fold here

Blood pressure (Obtained at rest) / mmHg

PHYSICIAN COMPLETE GREEN AREA

Physician Information

PHYSICIAN COMPLETE GREEN AREA

Physician's Name

Signed

Date / /

Medical License #

State of License

Telephone # - -

Ext.

14955

Health Support Program Notice and Consent

I consent to participate in Healthways' Health Risk Screening and Support Program (the "Program"), which may include providing biometric measurements such as weight and blood pressure, disclosing laboratory results from a recent blood test with my personal physician, and/or completing an on-line or written Well Being Assessment. I understand that my participation in the Program is voluntary and that I am not required to participate as a condition of employment or of enrollment in my health plan.

I understand and consent to my personal physician providing to Healthways results from a blood draw and laboratory analysis performed by my physician between July 1, 2012 and June 30, 2013 for the tests listed on the reverse side of this Form. I agree to execute any authorization form required by my physician prior to disclosing my results to Healthways. Such results will include lipids (cholesterol and components) and blood glucose measurements.

I consent to Healthways providing me with a report (either on-line or in writing) of my Program results and, if applicable, periodically providing me with follow-up educational materials and information relevant to my Program results. The laboratory results reflected in my report are for informational purposes only and are NOT a medical diagnosis.

I understand that the Program is sponsored by my employer or benefits provider. If an incentive is implemented as part of the Program, I consent to Healthways informing my Sponsor only whether or not I qualify for such incentive based upon my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

I understand that my individual health data will be used by Healthways and will be treated as confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individual health information will be shared between my physician or care provider and Healthways however not be shared with my employer. I understand that Healthways will not disclose my individual health information to my employer. Aggregated data (i.e., data with no individual identifiers) on all participants, however, may be shared with my employer.

I understand that my employer or benefits provider may from time to time offer enrollees other health and wellness services and programs (collectively, "Other Health/Wellness Programs"), such as employee assistance and/or disease management programs. I consent to the disclosure by Healthways of my wellness screening results and/or other personal health information that identifies me to Other Health/Wellness Program providers so that they may contact me for the purpose of addressing my particular health/wellness needs. I understand that Healthways and/or my employer or benefits provider will require such Other Health/Wellness Program providers to agree to maintain tile confidentiality of any wellness screening results and/or other personal health information provided to them by Healthways in accordance with the applicable regulations under HIPAA.

I understand that if I do not want Healthways to disclose my wellness screening results and/or other personal health information to Other Health/Wellness Program providers sponsored by my employer or benefits provider, I must notify Healthways in writing at: Healthways, Inc., 701 Cool Springs Blvd., Franklin, TN 37067, Attn: MHIQ.

I understand that this consent will remain in effect for as long as I participate in the Program, and that I am entitled to a copy of this consent. I may revoke this consent at any time by notifying Healthways in writing, to the extent Healthways has not already relied on this consent.