

Take Charge! Live Well!

How to Complete Your Online Physician Form





Physician Form

- To access the online physician form, visit ohio.gov/tclw and click on the “Physician Form” button

A screenshot of the 'Take Charge! Live Well!' website. At the top, a blue banner reads 'Welcome to Take Charge! Live Well! – the health and wellness site for state employees and their spouses'. Below this is a large banner for the 'Diabetes Management Program' with the text 'Learn how to manage your diabetes including supplies, coaching and medications' and a red 'Read More' button. Underneath the banner is a navigation bar with four buttons: 'Let us help you quit', 'Earn rewards for improving your health', 'Diabetes Prevention Program', and 'Manage your diabetes'. Below the navigation bar is a grid of blue buttons with orange and green accents. The buttons are: 'Biometric Screening', 'Well-Being Assessment', 'Program Guide', 'Physician Form' (circled in orange), 'Healthways Website', 'Webinars', and 'Shout Your Success'. At the bottom of the page, there are several horizontal lines in various colors (orange, green, blue, purple).



Physician Form: Login

- The “Physician Form” button will redirect you to the Physician Form website login page. Please note that the new fax number for completed physician forms is listed on this page
- When completing the login fields, please enter your name exactly as listed in the OAKS system



To obtain a Physician Form, please complete the fields below and click submit.

Please enter your complete name as listed in the OAKS system. Abbreviated and/or nicknames will not be recognized.

All fields are required.

Completed forms can be mailed, fax & uploaded. New fax number: **614-448-9922**

First Name	<input type="text"/>
Last Name	<input type="text"/>
DOB (mm/dd/yyyy)	<input type="text"/>
Zip Code (from your home address)	<input type="text"/>
Gender	<input type="radio"/> Male <input type="radio"/> Female



For questions about the Physician Screening Form, please contact Healthways Customer Support at (866) 556-2288.



Requesting a Physician Form

- To obtain a physician form, click on the “Request a physician form” link

Welcome to the Healthways online physician form site.

On this site you can either request a physician form or submit a form that has been completed by your physician.

Please select the appropriate link below.

[Request a physician form](#)

[Submit a physician form](#)

In order to use this function, you must be able to scan the completed form, save it to your computer in a **PDF** or **TIF** format, and upload it to this website.

Any other format, such as Word (.doc), cannot be processed.

Please ensure physician has signed the form before submitting.

[Logout](#)





Requesting a Physician Form

Based on your input we located:

First Name: John

Last Name: Member

DOB 10/19/1984 12:00 AM

Zip Code: 43215

Please select one of the below:

I AM the participant named above and I understand that this form can only be used to document my personal health information and for no other members use including my spouse or dependents

Submit

[I am NOT the participant named above. I need to return to the home page.](#)

- Next, verify the information listed on this page matches your personal information. If it matches your information, make sure to check the box and click the Submit button
- If the information listed is **not** your personal information, click on the link at the bottom of page to make sure you entered the correct information in the login page. If you receive the wrong information again, contact customer service for assistance.



Health Support Program Notice and Consent

- Next, you must agree to the Health Support Program Notice and Consent terms and conditions. Please check the box and click Submit

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, 2014 and June 30, 2015 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 the 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.

 I agree to terms of Notice and Consent



Email Notification

If you would like to receive a notification when your form has been successfully received and processed, a valid email address is required.

Please confirm the email address for this notification by entering and re-entering that email address below.

Email address

Re-enter





You will receive notification of the status of your form within 72 hours of being received.

- If you would like an email notification to be sent once your form has successfully been **received**, input the email address that you would like the notification sent to, and click the “Submit”
- Otherwise, click the “Skip” button





Instructions

- Next, the physician form PDF document will open up. The first page of this document includes instructions for the portion of the form that is to be filled out by the participant, as well as how your physician should complete the form
- The last part of this page lists submission instructions, including how to mail, fax, or upload your form online



Physician Screening Form Instructions

This form is for plan year July 1, 2016 through June 30, 2017 only and cannot be used for any other plan year

Print the entire document. If a photocopy of the form is submitted, it will not be processed.

This document includes:

- Physician Screening Form Instructions
- Screening Results Page
- Health Support Program Notice and Consent

Completion Instructions for Participant:

The Participant Information section of the Screening Results Page is prepopulated. Please fill in any missing information using black pen to ensure all fields are completed. **If the prepopulated information on your form is altered in any way 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*. This form can only be used to document your personal health information and cannot be used for your spouse or dependents.

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 and fill in the corresponding bubbles using blue or black ink. The results must be collected between 7/1/16 and 6/30/17. Standard methods to obtain the biometric

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

1. **Ensure all fields are completed on the form.** Make a copy for your records.
2. **Return completed "Screening Results Page" by mail, fax to 614-448-9922 OR scan.** Retain fax confirmation for your records.
(MAIL) HEALTHWAYS
C/O Abbvay USA-Digital Documents Division
PO Box 361290
Milpitas, CA 95036-1290
(SCAN) Visit <https://www2.d-docs.com/stoh>, enter required credentials and select the link that states "I would like to submit my completed physician form."

- Incomplete forms will not be processed.
- In order to receive your \$25 bonus incentive, your Well-Being Assessment and Physician Form must be completed (no missing information) and received by November 30, 2016.
- In order to receive your biometric screening incentive outside of the bonus deadline, your form must be received by June 30, 2017. If you are mailing your form, please take into account delivery time so that your form is received by the due date. **Forms received after June 30, will not be processed or incented.**
- If you provided your email when you printed your Physician Form, you will receive a notification within 72 of hours of when your form has been successfully received and processed. If you don't receive an email notification, you should check to make sure your form is completed and resubmit it.
- Complete Physician Forms can take up to 20 days to process. After this time, you can verify that your form was received by going to ohio.gov/tclw and logging into the Healthways Website. Your lab results will be found in the Resources and Tools tab under Health Record. If you do not see your results listed, and you have allowed at least 20 days, please resubmit your form. **Please note that all requests must be received by June 30, 2017 to receive the incentive.** It is up to members to verify that completed forms have been received prior to this deadline. We are unable to award points for forms received after this date.



Pre-Filled Section

0420

We will be unable to process this form if the pre-printed participant information below is altered.

FOR PARTICIPANT USE ONLY	Participant Information	Last Name	SMITH										Member ID																	
		First Name	JOHN										1 2 3 4 5 6 7 8																	
		Preferred Phone Number					Ext.				Date of Birth: / /				Gender <input type="radio"/> M <input type="radio"/> F															
		Preferred E-mail Address																												
		Medical History: Select any conditions you have or have had:																												
		<input type="radio"/> Heart Disease <input type="radio"/> High Cholesterol <input type="radio"/> High Blood Pressure <input type="radio"/> Diabetes																												

The first section of the physician form is pre-filled with your first and last name, State of Ohio User ID, date of birth, and gender. The remaining portion of this section is to be filled out by the participant.





Physician Form

- Section 2 and 3 are to be completed by the physician. Section 2 includes fields for your lab result information, while section 3 includes physician information
- Please make sure all fields are completed by your physician in section 3, including your physician's signature. Forms cannot be processed without a physician signature

PHYSICIAN COMPLETE THIS BOX		Measurement fields below REQUIRED in order to process. Document the measurements in the written section and ensure you fill in the bubbles under each measurement completely. Please use blue or black ink and do not use X's to indicate your responses in the bubble section.					
FOR PHYSICIAN USE ONLY	Biometric Measurements	Height (Obtained without shoes, measured to the nearest 1/4 inch)	Waist Circumference (Measured at the navel. Round down to the nearest inch)	Total Cholesterol	LDL	Fasting Glucose	
		<input type="text"/> ft <input type="text"/> in.	<input type="text"/> in.	<input type="text"/> mg/DL	<input type="text"/> mg/DL	<input type="text"/> mg/DL	
		1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	1 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
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FOR PHYSICIAN USE ONLY	Physician Information	Weight	Blood Pressure (Obtained at rest)	HDL	Triglycerides		
		<input type="text"/> lbs.	<input type="text"/> / <input type="text"/> mm/HG	<input type="text"/> mg/DL	<input type="text"/> mg/DL		
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		PHYSICIAN COMPLETE THIS BOX FORM MUST CONTAIN ALL PHYSICIAN INFORMATION BELOW IN ORDER TO PROCESS THIS FORM.					
		Physician's Name				Date of Service	
		<input type="text"/>				<input type="text"/> / <input type="text"/> / <input type="text"/>	
		Medical License #				State of License	
		<input type="text"/>				<input type="text"/>	
Telephone #		Ext.		Signature Date			
<input type="text"/>		<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>			
Signed <input type="text"/>							



Health Support Program Notice and Consent

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.

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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.

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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.

- The final page of the document includes a copy of the Health Support Program Notice and Consent form, which you previously agreed to
- Please retain this copy for your records



Submitting Physician Forms

- If you would like to submit your form online, login the same way you attained your physician form, and selecting “Physician Form.” Once on this page, click on the “Submit a physician form” button.
- If you wish to submit your form through fax, retain a copy of the fax confirmation to keep for your records. Remember, you should use the new fax number of 614-448-9922.

Welcome to the Healthways online physician form site.

On this site you can either request a physician form or submit a form that has been completed by your physician.

Please select the appropriate link below.

[Request a physician form](#)

[Submit a physician form](#)

In order to use this function, you must be able to scan the completed form, save it to your computer in a **PDF** or **TIF** format, and upload it to this website.

Any other format, such as Word (.doc), cannot be processed.

Please ensure physician has signed the form before submitting.

[Logout](#)



Uploading Physician Forms

- Follow steps 1-4 to submit your document. Please note, that your scanned document must be saved in a PDF or TIF format to be submitted

To upload your form, complete the following steps:

1. Scan your completed form and save it to your computer
2. Select, 'Choose File' or 'Browse' below
3. In the window provided, locate your completed physician form, highlight it, and select 'Open'
4. Wait for process to complete. A message will be displayed which states: "File Upload Complete"

Note: The form you upload MUST be the form downloaded from this site.

Choose File No file chosen



Successfully Uploading Physician Forms

To upload your form, complete the following steps:

1. Scan your completed form and save it to your computer
2. Select, 'Choose File' or 'Browse' below
3. In the window provided, locate your completed physician form, highlight it, and select 'Open'
4. Wait for process to complete. A message will be displayed which states: "File Upload Complete"

Note: The form you upload MUST be the form downloaded from this site.

Choose File

John_Member.pdf

File Upload Complete – Size of John_Member.pdf is 389886 bytes and content type is 'application/pdf'. PLEASE CLOSE CURRENT TAB

- Once you have successfully uploaded your document, you will see a page similar to this, with a note at the bottom stating your file upload is complete



THANK YOU!

For questions or further assistance,
please call Customer Service at 1-800-556-2288
or visit ohio.gov/tclw.

