2017 MSD Wayne Township Provider Option Form

Instructions to complete this form:

1. Print form
2. Complete all participant information
   a) Participant MUST sign form to be considered complete
3. Visit facility for biometric screening
   a)Take form to appointment
   b)Physician MUST sign this form to be considered complete
4. Complete all biometric information fields
5. Submit completed form by **December 1, 2017,** only submit form once using one method listed below. **It is the participant's responsibility to submit the form, not the physician's office.**
   a) Fax securely to (402) 881-8422
   b) Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127 (Forms will be accepted if TotalWellness receives forms in mail by 12.1.2017)

You will receive a confirmation e-mail approximately 5 business days after the form has been submitted. PLEASE DO NOT fax this form more than one time unless you do not receive a confirmation e-mail after 5 days of submission. If you do not receive an e-mail confirmation, please re submit your form (Please re-submit your form one time only). A confirmation of receipt cannot be sent without a valid email address being provided.

PARTICIPANT INFORMATION:

First Name: _____ Last Name: _____

Last 4 Digits of SSN _____

Primary Phone Number: ___ — ___ — ____ Date of Birth: (mm/dd/yyyy) __ / __ / ____

Email: _____

Gender:	O Male	O Female	
Have you fasted for at least 8 hours? *"No Food. Only water and black coffee permitted."*	O Yes	O No	
Are you currently pregnant or up to 12 months postpartum?	O Yes	O No	Delivery Date:___/___/_____
Within the last 6 months have you used any tobacco products?	O Yes	O No	

Physician's Name:_____ Physician's Phone Number:_____

Physician's Signature:_____

BIOMETRIC INFORMATION

Date of Screening: (mm/dd/yyy)	**Height:**		**Weight:**	**Waist Circumference:**	**Blood Pressure:**	
	Ft.	Inches	Lbs.	Inches	Systolic	Diastolic
__ / __ / ____			____.__			

Total Cholesterol:	**HDL:**	**Ratio TC/HDL:**	**LDL:**	**Triglycerides:**	**Glucose:**	**HbA1C:**

Consent Information: This information along with any personal health information provided in completing the Health Survey is maintained in a secure area within the Wellness Department to be used only for calculating these incentives for Indiana University Health's health plan and is not shared with your immediate supervisor. Healthy Results will provide my employer aggregate information as part of a group summary report (individual data will not be disclosed.)

IU Health uses some of its subsidiaries and affiliates to carry out the work of its wellness program. To the extent it is necessary for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties,.

By submitting this form, I hereby consent to this use of my health screening information and grant any such wellness program associate permission to contact me regarding my results.

I understand that TotalWellness may utilize the above health information to track participation and provide me with health guidance. This information will be used to provide confidential services to me and to gather anonymous statistical data for my company. I understand that my basic statistics will be aggregated and presented in reports only to show trends in health conditions and use of services. No personal health information will be provided to my company. Biometric data or personal identifiers (i.e. date of birth, name, etc.) may be transferred to a 3rd party for reporting and/or incentive tracking.

I certify that the information supplied on this form has been provided to me by my health care provider, and TotalWellness may contact my provider regarding the information.

Participant Printed Name: _____

Participant Signature: _____ Date: _____

64761

Please fax this form to: (402) 881-8422
or mail to
TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127

© Copyright 2016-2017 VSA,

Indiana University Health