

PHYSICIAN SCREENING FORM

PLEASE PRINT ALL INFORMATION CLEARLY

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (MM/DD/YYYY):
Blue Cross & Blue Shield of Rhode Island ID #:		

Wellness Program Notice and Consent - I authorize the following persons (each, an "Authorized Person") to use or disclose the information obtained on this Physician Screening Form, including my contact information and biometric screening data: Blue Cross & Blue Shield of Rhode Island, and/or the subcontractors, consultants, employees, officers, directors, agents and business partners of Blue Cross & Blue Shield of Rhode Island and my employer (the "Program Sponsor(s)"). The information obtained on this form may be used or disclosed by the Authorized Persons to provide me with materials that I may find useful, to contact me regarding health-related topics and/or programs, and to manage participation data and incentive campaign(s). I understand that the Authorized Persons are either directly subject to the requirements of HIPAA or are bound by contract to comply with the provisions of HIPAA and are prohibited from disclosing my information except as required by law, regulation, court order, subpoena or similar judicial or legal process. In the event of a disclosure required to comply with law, regulation, court order, subpoena, or similar judicial or legal process, I understand that the information disclosed may be subject to disclosure by the recipient and may no longer be protected by HIPAA. I understand that I may withdraw this Authorization at any time by delivering written notice of my intent to withdraw to Blue Cross & Blue Shield of Rhode Island, 500 Exchange St, Providence, RI 02903. I am aware that my withdrawal will not apply to authorized disclosures that were made prior to my withdrawal. I understand that Blue Cross & Blue Shield of Rhode Island and/or the Program Sponsor(s) may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization will remain valid for one (1) year from the date signed, unless withdrawn in writing. I understand that I have the ability to print a copy of this Authorization. By signing below, I acknowledge the Wellness Program Notice and Consent.

Member's Signature: _____ Date: _____

ONCE YOUR PHYSICIAN HAS COMPLETED THE REVERSE SIDE, PLEASE SUBMIT FORM BY MAIL OR FAX

<p>MAIL: The Wellness Company 317 Warren Avenue East Providence, RI 02914</p>	<p>FAX: (401) 461-3825 Keep a copy of your fax confirmation for proof of submission.</p>
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Physician, please fill out other side.

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For the screenings listed below, please record and verify the 2020 results for your patient. If a particular screening was completed at another location, such as an on-site wellness fair, there is no need to include that information.

If you determine that additional screenings are needed, please check the appropriate boxes:

- Body Mass Index
 Blood Pressure
 Glucose
 Total Cholesterol

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2020 SCREENING RESULTS

BMI RESULTS

Screening Date: _____

Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ Weight: _____ lbs.

BLOOD PRESSURE SCREENING RESULTS

Screening Date: _____

Systolic: _____

Diastolic: _____

GLUCOSE SCREENING RESULTS

Screening Date: _____

Glucose Level: _____ mg/dL

TOTAL CHOLESTEROL SCREENING RESULTS

Screening Date: _____

Total Cholesterol: _____ mg/dL

PHYSICIAN CERTIFICATION (This form must be signed and dated below.)

I can attest that the patient listed has received the medical screening(s) as indicated, as well as any necessary treatment and/or counseling.

Name of Physician: _____

Physician Address: _____

Physician Telephone Number: _____

National Provider ID (NPI): _____

Physician's Signature: _____ Date: _____