2021
Physician Screening Form

KETTERING Health Network

Corporate Outreach

This form must be submitted to our Corporate Outreach Department no later than **07/19/20H1** to qualify for the wellness incentive for completing the Kettering Health Network 20HЛ Biometric Screening. Examination and blood work must be completed between **0ф/13/2020 and 07/19/20H1** for the form to be accepted.

PLEASE USE ONE METHOD FOR SUBMITTING YOUR RESULTS:
E-mail: ketteringhealthplan@ketteringhealth.org
or FAX to 937-522-9190 or in-house at 29190

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY TO RECEIVE YOUR PLAN INCENTIVE

SECTION I: *TO BE COMPLETED BY YOU* (PLEASE PRINT)

First Name:_____ Last Name: _____ Last 4 SSN:_____

UMR Member ID #: _____ Date of Birth: _____ Gender: ☐Male ☐Female

Address: _____City: _____State: _____ Zip Code: _____

Confirmation Email:_____ Confirmation Phone Number: (_____)_____

Are you: ☐Employee ☐Spouse | Spouse's Name (if on KHN plan)_____

Release of Liability Informed Consent
I represent that my participation in this Biometric Health Screening is voluntary. My personally identifiable health information will be held confidentially and will only be shared with my employer-sponsored group health plan and its agents to provide health management and/or disease management services including data aggregation [on an unidentifiable basis] for program improvement purposes. However, the Kettering Health Network benefits administration team will be advised of the fact of my participation in the Biometric Screening for the purpose of awarding incentives. The safeguarding of personally identifiable health information is of great importance to Corporate Outreach, which protects such information from unauthorized access or use in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Release of Liability Informed Consent - Kettering Health Network - Health and Welfare Plan

I represent that my participation in this Biometric Health Screening and the Kettering Health Network wellness program is voluntary. I understand that I may withdraw from the Biometric Health Screening or the wellness program at any time.

I understand that the Kettering Health Network Health and Welfare Plan (the "Plan") is in compliance with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") health information privacy and security requirements. Therefore, my personally identifiable health information will be held confidentially by the Plan and its agents and not shared with my supervisor or anyone in my management team.

By signing this form, I understand that my personally identifiable health information may be shared by the Plan with my healthcare and care management providers under the Plan, to the extent permitted by law, to provide health care management and/or disease management services including data aggregation for program improvement and care coordination purposes. The safeguarding of personally identifiable health information is of great importance to the Plan and its agents, and such information is protected from unauthorized access or use in accordance with HIPAA.

I also understand that the Plan is committed to helping me achieve my best health. Rewards for participating in the Biometric Health Screening and the Kettering Health Network wellness program are available to all employees.

Please note: For any questions about the health plan or wellness program please call myHR at 1-844-235-4647 (externally) or ext. 70000 (internally). myHR does not have access to your biometric testing results, but can answer general questions about the process. To view Kettering Health Network's Notice of Privacy Practices, please visit Resources in the KHN myHR portal, Benefit Solver portal and the Wellness intranet page.

Participant Signature:_____ **Date:**_____

SECTION II: *TO BE COMPLETED BY PHYSICIAN/PROVIDER*

Examination and Blood Work Date: _____ **Only dates between 9/13/2020 & 07/19/2021 will be accepted**

Blood Pressure: _____ / _____ Height: _____feet _____inches Weight: _____ pounds

Total Cholesterol:_____mg/dl HDL: _____mg/dl Triglycerides: _____ mg/dl

LDL:_____mg/dl TC/HDL Ratio:_____ Glucose:_____mg/dl

A1c (optional):_____

Physician/Provider Signature: _____ **Date:**_____

Physician/Provider First & Last Name: _____

Address: _____

Phone Number: (_____)_____