SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Mosinee School District

Provider Fax Results

Participation-based

The Security Health Plan member presenting this form is participating in a worksite wellness program through Mosinee School District. This form should be used for an annual preventive exam that includes routine biometric screening. A preventive exam is a comprehensive medical evaluation focused on early detection and disease prevention.

Fax the completed form to Security Health Plan at 715.221.9278 by November 30, 2017. Results must be submitted by the provider. **Incomplete faxes and self-reported results by the member will not be accepted. The member is responsible for ensuring that the form is faxed.**

Instructions for members

Complete your preventive exam and biometric screening with your provider by November 30, 2017.

Complete **Section 1: Member Information** including signature, before meeting with your provider. Provide this form to your provider at your scheduled preventive exam. **Keep a copy of your lab results for your records.**

The cost of your annual preventive exam, including the required biometric screening listed, is covered at 100% if the exam is provided by an in-network provider or if you have an Indemnity Plan through Security Health Plan. You will not be responsible for a copay or coinsurance for the preventive exam or the biometric screening if billed appropriately by your provider. If additional tests or consultation occur beyond what is covered with your preventive exam, you might be responsible for out-of-pocket expenses. Contact Security Health Plan Customer Service if you have questions about benefits at 1.800.472.2363.

In order to have accurate results, you must fast (no food) for 8 – 12 hours before testing. However, your provider may advise you differently. Always follow your provider's instructions.

To get the most out of your exam, talk with your provider about your health risks and lifestyle behaviors. Ask your provider if there are any age- or gender-specific exams that should be completed (such as mammogram or colorectal exams).

If you are pregnant, please have your provider indicate "pregnant" on this form and submit. You are not required to have all biometrics entered.

Release and Use of Information Consent

I authorize my provider to disclose the health information described on this form to Security Health Plan. The purpose of this disclosure is to verify the biometric test results required as part of my employer group's worksite wellness program and to post my results to my personal health assessment. This authorization will remain in effect for 3 months or until I am no longer covered by Security Health Plan, unless I revoke this authorization in writing (at any time) as described by the Security Health Plan Notice of Privacy Practices (copy available upon request). I understand Security Health Plan will not condition my enrollment or eligibility for benefits on providing this authorization. I understand Security Health Plan will not voluntarily disclose my personal health information to my employer or any other third party without my specific authorization or as permitted by law.

I understand that I am entitled to retain a copy of this signed authorization.

Instructions for providers

Complete sections 2 and 3. Fax only the completed sections to Security Health Plan at 715.221.9278 (this is a specific fax number for this employer group) by November 30, 2017. Incomplete or late submissions of this form might delay or eliminate your patient from program incentives. Do not "batch" fax patient forms. Laboratory reports should not be faxed. Only data entered on this form will be accepted.

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Customer Service
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Mosinee School District

Provider Fax Results

Participation-based

Section 1: Member Information *(please print clearly)*

Member number (found to the left of your name on your Security Health Plan membership card)	Group name
☐☐☐☐☐☐☐☐☐☐	**Mosinee School District**

Last name (print)	First name	MI
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐

Email (optional)	Date of birth
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐☐/☐☐/☐☐

Member signature _____ Date (mm/dd/yy) ☐☐/☐☐/☐☐

Section 2: Biometric and Screening Tests as Part of a Comprehensive Preventive Exam *(please print clearly)*

Exam date (mm/dd/yy)	Fasting (8 – 12 hours):	Pregnant:	Member due for next preventive exam in:
☐☐/☐☐/☐☐	◯ Yes ◯ No	◯ Yes ◯ No	◯ 2018 ◯ 2019

Required Biometric Screenings

The following measurements must be completed to process this form.

Height	Weight	Body mass index (BMI)	Waist measurement	Blood pressure
☐☐.☐☐ in.	☐☐☐ lbs.	☐☐.☐☐	☐☐.☐☐ in.	☐☐☐/☐☐☐

Tobacco status:

◯ Patient uses tobacco ◯ Patient does not use tobacco

Additional Screenings

Complete the following screenings based upon your clinical practice guidelines and the U.S. Preventive Services Task Force (USPSTF) recommendations.

LDL cholesterol	HDL cholesterol	Total cholesterol	Blood sugar	Triglycerides
☐☐☐ mg/dL	☐☐☐ mg/dL	☐☐☐ mg/dL	☐☐☐ mg/dL	☐☐☐ mg/dL

Immunizations and Preventive Screenings

Member is up-to-date on all recommended immunizations: ◯ Yes ◯ No

◯ If no, recommendations were discussed with member.

Member is up-to-date on all age, gender and family history-specific preventive screenings: ◯ Yes ◯ No

◯ If no, recommendations were discussed with member.

Section 3: Provider Information *(please print clearly)*

Provider/Clinic name	Phone number
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐☐☐-☐☐☐-☐☐☐☐

Provider signature _____ Date (mm/dd/yy) ☐☐/☐☐/☐☐

Fax to Security Health Plan at 715.221.9278 *(this is a specific fax number for this employer group).*

