THE OHIO STATE UNIVERSITY
HEALTH PLAN

2018 Biometric Health Screening Form

Dear Physician/ Provider:

I am participating in The Ohio State University health and well-being program, Your Plan for Health (YP4H). I have agreed to complete a biometric health screening. These numbers are needed to earn additional incentives and will need to be provided to The Ohio State University Health Plan, Inc. (OSUHP). Please complete Section 2 below and fax the completed and signed form to the OSUHP at (614) 688-9670.

Please Note: It may take up to 30 calendar days for this form to be processed.
If this form is submitted near the end of the program year (Program ends December 31, 2018), it may not be processed in time to earn your 2018 incentives, please plan accordingly.

SECTION 1: TO BE COMPLETED BY YOU, THE MEMBER (Please Print)

Last Name*

First Name (Legal Name)*

Birth Date (MM/DD/YYYY)*

Best way to reach you with questions, please include the following & check the preferred method to reach you:

- ☐ Phone: (____)_____
- ☐ Email: _____

Please read and sign the following disclosure statement: I understand that my biometric screening data will be released to The Ohio State University Health Plan, Inc. for the purposes of follow-up health education and disease management, data aggregation for program improvement purposes, and/or for the purposes of updating my Personal Health and Well-being Assessment. I understand the collection of my health screening data is voluntary and my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA).

All requested information must have been measured after 12/1/17 to be considered for 2018 incentives. Incomplete forms will not be processed.

Participant/Patient Signature*: _____ **Date**: _____

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN / PROVIDER

Exam Date: ____/____/____ Gender: Male Female

Height: _____ Feet _____ Inches Weight: _____ Pounds BMI:_____ Pregnant: Y / N / NA	Blood Pressure: _____/____mmHg Pulse: _____

BLOOD PANEL

CHOLESTEROL	GLUCOSE or A1C (required)
Total Cholesterol: _____ mg/dl	Fasting Status: ☐ Fasting
HDL: _____ mg/dl	☐ Non-Fasting
	Blood Glucose:_____ **OR** A1C: _____

Physician/ Provider's Signature: _____ Today's Date: _____
Physician/ Provider's Name (Please Print): _____
Office Phone number: ( ) _____ Address: _____

Please fax completed form to OSU Health Plan at (614) 688-9670.
Please allow up to 30 calendar days for forms to be processed.
* Indicates a required field