THE OHIO STATE UNIVERSITY
HEALTH PLAN

2019 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, 2019), it may not be processed in time to earn your 2020 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)

Please provide your contact information.
Check the preferred method of communication if questions arise.

☐ 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, 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).

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

All requested information must have been measured on or after January 1, 2019 to receive credit for a 2019 verified biometric screening completion. Incomplete forms will not be processed. Forms should be submitted by December 24, 2019 to allow for enough processing time.

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN/PROVIDER

Exam Date: _____/_____/2019 Gender (circle one): Male Female Other

Height:_____Feet _____Inches
Weight:_____Pounds
BMI:_____ Pregnant (circle one): Yes No N/A

Blood Pressure:_____/_____mmHg
Pulse: _____beats per minute

BLOOD PANEL

CHOLESTEROL

Total Cholesterol: _____mm/dl
HDL: _____mm/dl

GLUCOSE or A1C (required)

Fasting Status (circle one): Fasting Non-fasting
Blood Glucose :_____ **OR** A1C: _____

Physician/Provider Information

Signature: _____ Today's Date : _____

Name (please print):_____Office Phone Number: (__ __ __) __ __ __-__ __ __ __

Address: _____

Please fax completed form to OSU Health Plan at (614) 688-9670.

Forms should be submitted by December 24, 2019 to allow for enough processing time.