THE OHIO STATE UNIVERSITY
HEALTH PLAN

2021 Biometric Health Screening Provider 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 send the completed and signed form to the OSUHP via fax at **(614) 688-9670** or send via secure email to **yp4h.clinicalservices@osumc.edu**

Please Note: It may take up to 30 calendar days for this form to be processed by OSUHP and Virgin Pulse.
Biometrics must have been measured during this calendar year to be considered. Incomplete forms will not be processed.

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 to confirm form is processed, please include both phone & email:

☐ 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).

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
Total Cholesterol:_____mg/dl
HDL:_____mg/dl

GLUCOSE or A1C (required)
Fasting Status: ☐ Fasting
☐ Non-Fasting
Blood Glucose:_____ **OR** A1C:_____

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

All fields are required. Please submit the completed form to the OSU Health Plan:
Fax: (614) 688-9670 or secure email to yp4h.clinicalservices@osumc.edu
Forms will be accepted until 5:00 PM on December 30, 2021
Upon completion of processing, an email confirmation will be sent to the email address above from yp4h.clinicalservices@osumc.edu

Last updated 12/20/2020