



2022 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. Provider offices can also submit this form by using secure email functionality by emailing this completed document 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 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).

Participant/Patient Signature\*: Date:

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN/PROVIDER

Exam Date: / / Patient Sex at Birth: Male Female

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

BLOOD PANEL

CHOLESTEROL
Cholesterol: mg/dl
HDL: mg/dl
GLUCOSE or A1C (required) Total
Fasting Status: Fasting or 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 20, 2022 for YP4H points
Forms will be accepted until 5:00 PM on December 30, 2022 for OSUHP premium credit