

Prior Authorization (Must complete before the Screening): I have read the enclosed Notice Regarding Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form and in other Wellness Program requirements may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

Participant Signature

Rachael Mann

SECTION 1: (To Be Completed by Active or Retired Employee or Spouse) PRINT CLEARLY WITH A BLACK INK PEN. DARKEN BOXES COMPLETELY.

PEEHIP PID: (not contract number)

Patient SSN: (required)

☐ Male

☐ Contract Holder

☐ Female

☒ Spouse

Screen Date:

Birth Date:

Zip Code:

07 - 20 - 2022

06 - 23 - 1983

36022

Last Name:

First Name:

Middle Initial:

MAN N

RACHAEL

H

Have you used a tobacco product or electronic smoking device in the last 12 months?

☒ Yes

☐ No

What best describes your race/ethnicity?

☒ White

☐ Asian

☐ Hispanic / Latino

☐ Other

☐ Black / African American

☐ Native American /

☐ Native Hawaiian / Pacific Islander

Alaska Native

Do you have (or have you been told you had) any of the following?

☐ High Cholesterol

☐ High Blood Pressure

☐ Diabetes

Do you take any medication for any of the following?

☐ High Cholesterol

☐ High Blood Pressure

☐ Diabetes

SECTION 2: (To Be Completed by Provider)

Blood Pressure: 197 / 99

Total Cholesterol: 199 mg/dl

HDL Cholesterol: 146 mg/dl

LDL Cholesterol: 114 mg/dl

Triglycerides 204 mg/dl

Blood Glucose: 89 mg/dl

Height: 5 ft 6 in

Weight: 248 lbs

BMI: 40

Screening not performed due to:

☐ Pregnancy

☐ Disability

CLAIMS FILING INSTRUCTIONS FOR COPAYMENT WAIVER: Only one routine office visit is covered per calendar year under the PEEHIP benefits. No copayment is required for one annual preventive routine office visit obtained through an in-network provider (not applicable if a diagnosis associated with the visit). File the claim for the member's office visit with BC/BS for PEEHIP Group #14000. Use the appropriate CPT code for the office visit in order to be reimbursed at 100% of the allowable fee. The patient will be responsible for any other applicable copays, such as lab tests. Incomplete forms will not be processed.

Lindsey Barton, CRNP

Healthcare Provider Name (Please Print)

L. Barton, CRNP

Healthcare Provider Signature

CRNP / Student Health Clinic

Healthcare Provider Type (Please Print)

7401 East Dr. Montgomery, AL 36117 (334) 244-3281

Healthcare Provider Address & Phone Number (Please Print)