UEBT Physician Biometric Screening Form

For: Currently Enrolled Blue Shield PPO Members and Spouses/Domestic Partners

(Please do not use this form if you are a current Kaiser HMO Member)

A BIOMETRIC SCREENING IS REQUIRED TO BE COMPLETED TO BE ENROLLED IN THE HEALTH CARE PARTNERSHIP PLAN OPTION LEVEL FOR THE 2017 PLAN YEAR.

The Health Care Partnership (HCP) Plan option has lower dependent premiums and reduces your out-of-pocket costs for your doctor visits, hospital stays, etc. If you are currently a Health Care Partnership (HCP) Plan Member or would like to be eligible to enroll in the HCP Plan option level for 2017, you and your Spouse/Domestic Partner must complete a Biometric Screening (Action Step). You do not have to wait until Open Enrollment to complete and submit your Biometric Screening. If you are planning an annual physical with your Primary Care Physician you can simply take the form attached (or download the HM7 form from the Trust Fund website at www.ufcwtrust.com) and have your Physician complete and fax the form to (650) 424-1000 before September 30, 2016. Additionally, once Open Enrollment begins, alternative options to complete your Biometric Screening (and other required Action Steps for Personal Direction Participants) will be available. Information regarding Open Enrollment will be sent out in July.

Instructions:

Your physician biometric screening form will allow your doctor to perform your biometric wellness screening for the 2017 Plan Year. To use this screening option, laboratory results must be received by MedExpert. **You are responsible for ensuring your doctor faxes the form directly to MedExpert, complete with all screening values and signatures.** Results received in any other format will not be accepted. Please follow these steps carefully:

- Schedule an appointment with your doctor. If you have already had your annual physical for the 2016 Plan Year (meaning, you had your physical on or after January 1, 2016), have your Physician record your biometrics on the attached form and fax it to (650) 424-1000. Please be aware that your physician's office may charge you a fee for a second physical as the Trust Fund will only cover one physical at 100% per calendar year. In addition, your Physician may apply a fee for completing the form. **Your physician's office is to submit the bill to Blue Shield's address shown on the back of your health plan ID card.**

- It is recommended you fast (not eat or drink anything but water) for at least 12 hours prior to your appointment. Continue taking medication as directed and be sure to drink plenty of water. Lab work must be completed between January 1, 2016 and September 30, 2016.

- You must sign and date the "Participant Signature" area section of the enclosed Physician Biometric Screening Form before providing the form to your doctor. **NOTE:** Participants and Spouses/Domestic Partners must each provide a separate form to their physician.

- Provide your Physician the "Physician Biometric Screening" form. Your Physician must complete the "Physician Office Completes" section of the form, including signature, date, and UPIN/NPI. The UPIN/NPI is a unique number that identifies your Physician's office; your Physician will know this number.

- Your Physician must fax the completed form to MedExpert at 650-424-1000. You are responsible for ensuring your Physician returns this form.

- **Only completed forms will be processed. If a form is submitted with missing information, you will have to have it submitted again, so please ensure that all items are filled out.**

- Additional information is located online at ufcwtrust.com under Resources and Forms.

For more information regarding this form or your other upcoming Action Steps (the Biometric Screening is considered an Action Step), please visit ufcwtrust.com or call MedExpert at 1-800-999-1999.

If you have questions about the Biometric Health Screening, eligibility or enrollment in medical plan benefits, please contact the Trust Fund Office. Receipt of this notice does not constitute a determination of your eligibility for benefits.

Healthy Measures

UEBT 1011 HM 7

HM.7 - PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

PLEASE PRINT CLEARLY AND STAY WITHIN THE BOXES BELOW

For office use only

MEMBER (EMPLOYEE) INFORMATION - Completion required.

First Name: Must match your organization's official use of your first name. (Middle Initial)

Last Name: Must match your organization's official use of your last name.

DOB: (Month) • (Day) • (Year)

Last 4 digits SSN:

Sex: ○M ○F

PERSON BEING MEASURED - Completion required.

Participant First Name: (Middle Initial)

Participant Last Name:

Participant DOB: (Month) • (Day) • (Year)

Last 4 digits Tester SSN:

Sex: ○M ○F

Participant Email:

Participant Phone: (Area Code)

Important: This form is ONLY for current UEBT Blue Shield PPO members and spouses/domestic partners who are electing a Health Care Partnership related plan (PPO or Kaiser HMO) for 2017 benefits.

By submitting this form, you are requesting your physician to report laboratory and biometric results to MedExpert for your Biometric Health Screening.

- *Please check the Healthy Measures website to verify you need a biometric screening test prior to having one done.*
- *You are responsible for ensuring your doctor returns this form by the deadline.*
- *For an individual participant, only one physician form can be submitted.*
- *See the Action Steps flyer in your enrollment materials for more details.*
- *Please retain a copy of this physician-completed form for your records.*

Participant's Signature: _____ **Date:** (Month) • (Day) • (Year)

UEBT 1011

Please fax this form to 1-650-424-1000

For more information, call the Healthy Measures Help Line at 1-800-999-1999

Healthy Measures

UEBT 1011 HM 7

HM.7 - PROVIDER DATA ENTRY FORM

GENERAL INFORMATION

Participant Last Name:

DOB: (Month) (Day) (Year)

Last 4 digits of your SSN:

FOR PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

Blood Pressure

Systolic

Diastolic

Cholesterol

HDL: TRI:

LDL: Total:

Total/HDL Ratio: .

Glucose

Fasting:

A1c: .

BODY MEASUREMENTS

Height: (in) Weight: (lbs) Waist: (in)

NICOTINE USER?

○ Y ○ N

Test Date: (Month) (Day) (Year)

TRACKING NUMBER

NOTE: Facility and agent name must be printed in the boxes.

○ I certify these values are correct

Facility Name:

Certifying Agent First Name:

Last Name:

NPI#:

Today's Date: (Month) (Day) (Year)

Signature: _____

NOTE: Use area below for office or facility stamp

UEBT 1011

Please fax this form to 1-650-424-1000

For more information, call the Healthy Measures Help Line at 1-800-999-1999