Georgia State Health Benefit Plan (SHBP)
Biometric Screening - Physician FAX Form

The Fax Form is to be used by eligible SHBP covered employees and spouses who would like to submit their Biometric Screening Data to CIGNA for completion of their SHBP WELLNESS Plan requirements.

2012 WELLNESS Plan requirements:

SHBP covered employees and their spouses who enroll in the WELLNESS Plan are required to complete a Biometric Screening at a SHBP sponsored screening event or as part of a physician's office visit or annual preventive examination. The following measures must be collected and reported through the screening entity or via this FAX Form sent directly from the Physician's office.

Self reporting of measures by an SHBP covered employee, retiree or Spouse is not accepted.

The following measures must be part of the Biometric Screening:

Height	**Total Cholesterol**	**LDL**	**BMI**	**Blood Pressure**
Weight	**HDL Cholesterol**	**Non-fasting Glucose**		**Waist Circumference**

To qualify for the 2012 WELLNESS Plan the screening must be completed between July 1, 2011 and June 30, 2012 and results submitted to CIGNA no later than June 30, 2012.

Instructions for SHBP Participant:

Complete Section 1 of the attached form including signature and present the form to your physician at your scheduled appointment. Instruct the physician to complete the required information and fax the form directly to CIGNA at the number indicated.

If you have already completed a screening (since July 1st, 2011) you may take the completed form to your physician and request completion of section 2 with your results and submission of the form.

Remember, your annual preventive care is covered at 100%. This means you are not responsible for a copay or coinsurance. Talk to your physician about using one of the following codes to make sure your visit is processed correctly:

99385 – New, Ages 18-39	99395 – Established, Ages 18-39
99386 – New, Ages 40-64	99396 – Established, Ages 40-64
99387 – New, Ages 65 & over	99397 – Established, Ages 65 & over

Forms must be received by June 30th 2012 to qualify.

Instructions for Physician:

Complete Section 2 of the FAX Form and fax to CIGNA at the number indicated.

Fasting results are not required but may be submitted if available.

2012 SHBP Biometric Screening PHYSICIAN FAX FORM
Fax to 860.256.6767

Dear Physician:

I am participating in the Georgia SHBP WELLNESS Plan. As a requirement of this plan I have agreed to complete a biometric screening as detailed on the previous page. Please complete SECTION 2 below and fax the completed and signed form to the CIGNA efax line *no later than June 30, 2012*.

Thank you.

SECTION 1: PATIENT INFORMATION*(**Patient** –Complete this section. Please print.)*

First Name:_____Last Name: _____

Address: _____City: _____ State: Zip: _____

Phone Number: (_____) _____ - _____ Insurance (CIGNA) ID#: _____

Gender: ❑male ❑ female Age: _____Date of Birth: _____

Please read the following disclosure statement:I understand that the collection of my health screening data is a requirement of participation in the SHBP WELLNESS Plans and my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge that I am voluntarily participating in this health screening.

Signature: _____ Date: _____

PATIENTS: Biometrics Screenings must be completed by June 30, 2012. If you have questions or need additional assistance, please call the number on your ID card.

SECTION 2: PATIENT BIOMETRIC VALUES*(**Physician** –Complete this section for the above patient. Please print)*

Required Screening Information

Exam Date: _____
Height: _____ ft _____ inches
Weight:_____ pounds BMI___
Waist circumference: _____inches
Blood Pressure: _____ / _____ mmHg
Total Cholesterol: _____ mg/dl
HDL Cholesterol: _____ mg/dl
LDL Cholesterol (fasting): _____ mg/dl
Glucose: ☐ fasting _____ mg/dl ***or***
☐non-fasting _____ mg/dl

Optional Screening information

Triglycerides (fasting): _____ mg/dl
Risk ratio: _____
Body Composition: _____%

Physician Name: _____Phone Number: ( ) _____ - _____
Fax #: ( ) _____ - _____Address: _____
City: _____ State:_____ Zip: _____
Signature: _____ Date: _____