Public Education Employees' Health Insurance Program
Screening Form / HEALTHCARE PROVIDER

TEAM UP FOR HEALTH

GET SCREENED FOR YOUR TEAM!

Incomplete forms will not be processed.

ADPH Wellness Program
201 Monroe Street, Suite 986
Montgomery, AL 36104
Phone: 1-800-252-1818
Fax: 1-334-206-0385

To Be Completed by Active or Retired Employee or Spouse:

SECTION 1:

PRINT CLEARLY WITH A BLACK INK PEN.

DARKEN BOXES COMPLETELY.
■ << Not This ■ **<< This** X << Not This

Contract Number:

SSN: (of person being screened) ___ - ___ - ____

☐ **Male** ☐ **Female** ☐ **Contract Holder** ☐ **Spouse**

Screen Date: __ - __ - ____

Birth Date: __ - __ - ____

Daytime Phone Number: ___ - ___ - ____

Last Name:

First Name:

Screening not performed due to: ☐ **Pregnancy** ☐ **Disability**

What best describes your race/ethnicity?

- ☐ White
- ☐ Hispanic / Latino
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ Asian
- ☐ Other
- ☐ Native American / 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

To Be Completed by Physician's Office:

SECTION 2:

SEE PHYSICIAN INSTRUCTIONS ON REVERSE SIDE ▶

Blood Pressure: ___ / ___

Total Cholesterol: ___ mg/dl

HDL Cholesterol: ___ mg/dl

LDL Cholesterol: ___ mg/dl

Triglycerides ___ mg/dl

Blood Glucose: ___ mg/dl

Height: __ ft __ in

Weight: ___ lbs

Waist: ___ . __ in

Has the patient used a tobacco product in the last 12 months? ☐ **Yes** ☐ **No**

CLAIMS FILING INSTRUCTIONS FOR COPAYMENT WAIVER: Under the Affordable Care Act, 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. The copay waiver is not allowed at urgent care centers or emergency rooms. Please follow the normal billing procedures for subsequent visits.

To Be Completed by Physician's Office:

Physician / CRNP, PA Name (Please Print)

Physician / CRNP, PA Signature

Healthcare Provider Type (Please Print)

Healthcare Provider Address & Phone Number (Please Print)

PEEHIP

ADPH
Alabama Department of Public Health

Healthcare Provider: please fax or mail to the **ADPH Wellness Program.**

PEEHIP Healthcare Provider Screening Form: Physician instructions

Section 2:

- Please completely capture all requested data and record it in the fields provided. While all data is highly useful, the PEEHIP member's wellness screening requirement will not be completed unless all of the data in section 2 is recorded at the time of the office visit with the exception of waist measurement.
- Waist measurement is not a required field for completion of the PEEHIP member's wellness screening requirement; however, collecting this information is recommended to better represent the distribution of body mass and determine overall wellness.

Signature Block:

- Please completely fill out all requested fields in order for the PEEHIP member's wellness screening requirement to be completed.
- Please mail or fax the completed form directly to the Alabama Department of Public Health at the address or fax number below.

ADPH Wellness Program
201 Monroe Street, Suite 986
Montgomery, AL 36104
Fax: 1-334-206-0385
Phone: 1-800-252-1818