LifeWise

LifeWise Health Plan of Oregon

Large Group Wellness Program*

Healthcare Provider Biometric Screening Form

SECTION 1 - EMPLOYEE INFORMATION - PLEASE ENTER YOUR INFORMATION

First Name | MI | Last Name

Date of Birth (Month) / (Day) / (Year) | Gender | Member Medical ID # | Suffix

Daytime telephone number – – | Email Address

SECTION 2 - OPTIONS - PLEASE SELECT OPTION A OR B

☐ **Option A - I WILL COMPLETE SECTION 3 and 4**
1) I have taken the lab values from my lab sheet and entered them into Section 3 of this form. I will fax my lab slip with this form. Provider signature is not required if Option A is selected.

☐ **Option B - MY PROVIDER WILL COMPLETE SECTIONS 3 and 4**
1) I have seen my Provider and my Provider will enter all values listed in Section 3 and sign as required. Either myself or my Provider will fax completed form to 1-**855-351-6378** .

SECTION 3 - BODY MEASUREMENTS / BIOMETRIC RESULTS

Height ft in | **Weight** lbs | **Glucose** | **Fasting** Yes ☐ No ☐ | **Blood Pressure** Systolic / Diastolic

Cholesterol
HDL: | TRI:
LDL: | Total:

Screening Date: (Month) (Day) (Year)

SECTION 4 - PROVIDER INFORMATION - PLEASE ENTER PROVIDER INFORMATION WHO COLLECTED BIOMETRIC VALUES

Facility Name: _____

Provider's Name: _____

Phone Number: _____

Provider Signature: _____

EXCEPTIONS: For Providers
If in your professional and medical opinion it is unreasonable due to a medical condition for this patient to complete the biometric screening, please check the box below and sign and date.

☐ I certify this patient should not complete the biometric screening, due to a medical condition.

Provider Signature: _____

Date: _____

SECTION 5 - EMPLOYEE SIGNATURE - PLEASE SIGN AND DATE FORM

By signing and faxing this form, I understand that my data will be shared with my health plan or the administrator of the applicable wellness program. My individual results will NOT be shared with my employer. LifeWise is committed to maintaining the confidentiality of your medical information. For details about how we may collect, use and disclose your personal information and your rights regarding that information, please see our notice of privacy practices, available at lifewiseor.com.

Employee's Signature: _____ (Month) (Day) (Year)

SECTION 6 - CONFIRMATION - PLEASE CONFIRM (Check) YOU HAVE COMPLETED ALL SECTIONS AND ACTIONS

___ **Section 1 - Employee information entered**
___ **Section 2 - Option A - Lab slip faxed with completed and signed form**
OR
Option B - This form collected from Provider after sections 3 and 4 are completed
___ **Section 3 - ALL Biometrics Data entered by employee or provider**
___ **Section 4 - Provider information entered including provider signature if Option B**
___ **Section 5 - Form signed by employee**
___ **Completed form faxed to1-855-351-6378**
___ **Copy of this form retained by employee**
For questions regarding the wellness program contact LifeWise of Oregon customer service

FORMS CANNOT BE PROCESSED UNLESS ALL SECTIONS ARE COMPLETED AND THE FORM IS SIGNED.

*The Large Group Wellness program is available to Large Groups with 51-99 enrolled employees, as they enroll and renew beginning January 1, 2015.

LifeWise

Discrimination is Against the Law

LifeWise Health Plan of Oregon (LifeWise) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWise does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. LifeWise provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). LifeWise provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that LifeWise has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-596-3440 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-596-3440 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-596-3440（TTY：711）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-596-3440 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-596-3440 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-596-3440 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-596-3440（TTY:711）まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-596-3440 (رقم هاتف الصم والبكم: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-596-3440 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-596-3440 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-596-3440 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-596-3440 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-596-3440 (TTY: 711) تماس بگیرید.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-596-3440 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-596-3440 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-596-3440 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-596-3440 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-596-3440 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-596-3440 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-596-3440 (TTY: 711).