



# 2017 Wellness Screening Form

For use in WA Small Group

1. Complete all sections — incomplete forms will not be accepted or valid.
2. Fax to: **1-860-900-7826** (Include any attachments needed, no cover sheet required)
3. Employee keeps completed copy and fax confirmation for records.
4. Questions? Contact Total Benefit Solutions at **1-800-514-4850**.

## Section A: Employee Details (all sections required)

Aetna Member ID Number

Group Number

First Name

MI

Last Name

Date of Birth

 /  / 

(Month) (Day) (Year)

Telephone Number

 -  - 

Email Address (Will only be used for Gift Card Delivery)

## Section B: Biometric Results (all sections required)

Please indicate how you will be submitting your results.

- Self Report (member completes Section B):** I am not due for a preventive screening yet based on the date of my last exam. I have included the results from my recent preventive exam (within last 12 months) below. I will attach a copy of my lab slip to this form for self-reporting. Provider signature not required for this option.
- Provider Reporting:** My provider will complete Section B & C. I have seen my provider and my provider will enter all values below and sign. Either I or my provider will fax this form in.

Height

 

ft in

Weight

 

lbs

Blood Pressure

   

Systolic

Diastolic

Glucose

 

Fasting

 

Yes No

Cholesterol

 

HDL

 

TRI

 

LDL

 

Total

Screening Date:

 /  / 

(Month) (Day) (Year)

Additional screening services beyond the routine yearly physical benefit may be subject to deductible, copay, or coinsurance. Please refer to your Summary of Coverage for details on the routine physical benefits.

## Section C: Provider Details (Licensed medical professional who collected results.)

Facility Name: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

- Provider Exception: (For Providers Only)** Complete this section if you feel in your medical opinion this patient has a medical condition that would make it unreasonable for them to complete the biometric screening. Please sign and date this section to certify this patient cannot complete the biometric screening due to a medical condition. Please include your provider details in Section C.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section D: Employee Signature - Sign and Date Form

Fax completed form to: 1-860-900-7826

By signing and returning this form to Aetna, I understand that my completion of this form will be shared with my health plan or the administrator of the wellness program. My individual results will NOT be share with my employer. Aetna keeps your information private and will confidentially handle your medical information. For more information on our privacy practices please see our notices available at [www.aetna.com](http://www.aetna.com).

Employee Signature: \_\_\_\_\_

Signature Date:

 /  / 

(Month) (Day) (Year)

Health insurance plans are offered, underwritten and/or administered by Aetna Life Insurance Company (Aetna).

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقةك الشخصية. (Arabic)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua identidade. (Portuguese)

Для получения бесплатной помощи переводчика позвоните по телефону, указанному на Вашей личной карточке медицинского страхования. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)