<u>2020 Biometric Screening Form</u>

To: Conway Regional Employees & Spouses Enrolled in CoreSource Insurance
Re: 2020 Annual Employee & Spouse Wellness Plan Biometric Screening

Our employees are important to us, and we encourage all Conway Regional Employees to participate in wellness visits and annual biometric screenings to gain important knowledge about your health status. One way to obtain this information is through your annual routine preventative exam.

Also, as specified in the Conway Regional Wellness Program details, all active Conway Regional employees who wish to qualify to receive a premium discount during the 2020 plan year must complete an annual wellness visit, including specified health screening **<u>during the time period of January 1, 2020 through July 15, 2020.</u>**

In order to receive the premium discount for the 2020 Plan Year, the Annual Employee Wellness Plan Biometric Screening guidelines require that all active employees and spouses on CoreSource schedule and obtain a wellness visit with their primary care provider, and complete the following screenings: Total Cholesterol, HDL, LDL, Triglycerides, Glucose Test, Blood Pressure, Height/Weight, and Nicotine Use.

If an employee fails to have a wellness exam *including* ALL the required screening by <u>July 15, 2020</u>, that employee will be ineligible to receive the monthly discount for a <u>*minimum* of three months</u> of the 2020 plan year. That means you will have to pay an additional $20 per paycheck towards the cost of your health insurance coverage. If a screening is not performed or completed paperwork is not turned in, the discount will be removed for the entire plan year.

Once your wellness office visit and all specified preventative screenings have been performed, this form must be completed by your provider and submitted via the instructions below.

<u>A COMPLETED Biometric Screening form MUST be submitted no later than July 15, 2020</u> or YOU WILL NOT BE ELIGIBLE for the reduced Health Premium Costs.

Ask your provider to complete the attached Biometric Screening form using exam and lab results from your Annual Wellness Visit. Again, the visit must be completed during the period of **1/1/2020 -7/15/2020.**

- ☐ **HEIGHT AND WEIGHT**
- ☐ **BLOOD PRESSURE**
- ☐ **TOTAL CHOLESTEROL**
- ☐ **LDL AND HDL**
- ☐ **TRIGLYCERIDES**
- ☐ **GLUCOSE**
- ☐ **NICOTINE USE**

The attached Biometric Screening Form can be faxed to (501-513-5355) emailed (lifestylecoach@conwayregional.org), or delivered to the Wellness and Diabetes Education Department located in the Women's Center in Building #2.

Please print clearly

CONWAY REGIONAL
HEALTH SYSTEM
WELLNESS & DIABETES
EDUCATION SERVICES

2020 Annual Employee & Spouse Wellness Plan Biometric Screening Form

Check the appropriate box below.

☐ I am an Employee of CR ☐ I am the Spouse of CR Employee ________________

Are you currently pregnant YES ☐ NO ☐

THIS SECTION TO BE COMPLETED AND SIGNED BY THE EMPLOYEE OR SPOUSE:	
Full Name:	
Employee Badge Number:	
Date of Birth:	Gender:
Preferred Telephone Number:	**Preferred Email Address:**
THIS SECTION TO BE COMPLETED AND SIGNED BY THE **EMPLOYEE**	
Do you work ☐ Onsite ☐ Off Site; Clinic: ________ Day Shift ☐ Night Shift ☐ Weekends ☐	

Note: Medical providers completing wellness screenings should only use wellness codes when filing a claim. Wellness screenings under the CRMC health plan are paid at 100% with no co-pay. If the wellness screening by the provider includes additional screenings, tests, diagnosis, etc. beyond the wellness screening, then a co-pay may be required.

BY SUBMITTING THIS FORM TO CONWAY REGIONAL (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:
Conway Regional treats personally identifiable health information as confidential. The information you provide to us on this form will be used in conjunction with Conway Regional's Employee Wellness Plan. This Wellness Program complies with all standards set forth by the EEOC, including, but not limited to, the ADA of 1990, GINA of 2008, and HIPPA regulations.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at Conway Regional's discretion):

- Authorized Conway Regional employees;
- Authorized individuals working for Conway Regional or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by Conway Regional in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for Conway Regional's health and wellness plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those whom we are required to share your information by applicable law, court orders or government regulations.

I hereby authorize the medical facility listed below to release biometric assessment data to Conway Regional.	
Facility Name:	Telephone Number:
Participant Signature:	**Date:**

BIOMETRIC ASSESSMENT: MEDICAL HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW		
Are you fasting? This means you have NOT had anything to eat or drink other than water or coffee/tea without sugar or cream in the last 9-12 hours. Note: *If you have not fasted you may still participate, however, some of your measurements may be affected.*		☐Yes ☐No
Height in **Inches**:	LDL:	Triglycerides:
Weight in **Pounds**:	HDL:	Glucose:
Blood Pressure: /	Total Cholesterol:	Nicotine Use? ☐Yes ☐No
Medical Health Care Provider Name (Please Print):		
Medical Health Care Provider Signature:		Date: