2018 Wellness Screening Form

For use in WA Small Group

1. Complete all sections and return within first 90 days of group plan effective date — incomplete forms will not be accepted or valid. Employee keeps completed copy and fax confirmation for records.
2. Fax to: **1-860-900-7826** (Include any attachments needed, no cover sheet required)
3. Log in and complete/update health assessment on your personal Aetna Navigator® site before the deadline.
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 you 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**.

Employee Signature: _____ Signature Date: (Month) / (Day) / (Year)

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

We provide 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.

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).

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TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.