

BIOMETRIC SCREENING FORM INSTRUCTIONS

IF YOU ARE OBTAINING YOUR SCREENING AT A KROGER PHARMACY, LITTLE CLINIC, OR IF YOU ENROLLED IN KAISER AND YOU USE A KAISER MOBILE HEALTH VEHICLE OR MEDICAL CENTER, DO NOT USE THIS FORM.

Completion Instructions for Participant:

Complete the *Participant Information Section* of the *2019 Biometric Screening Result Form*. Print legibly and make sure you complete ALL fields in this section.

Completion Instructions for Provider:

Complete all requested items in the section labeled *Biometric Measurements and Physician Information*.

1. Biometric Measurements

Provide the numeric value of patient's biometric measurements and blood test. The results should be collected between January 1, 2019 and September 30, 2019.

2. Physician Information

Complete this section, sign and date the form in the areas provided.

Office visits for Biometric Screenings should be coded as preventive care physical exam/health screenings in order to be covered at 100% under the Fund's preventive care benefits.

Submission Instructions:

Once all sections of the form have been completed, follow the instructions below to ensure receipt of your *Biometric Screening Result Form* for processing. If you have any questions regarding the process, please contact the Fund Office at 770-997-9910 or toll-free at 1-800-241-3473.

1. Ensure all fields are completed on the Form.

Once all items are completed, make a copy for your records.

2. Return the completed "Biometric Screening Results" page by fax (preferred) or mail:

FAX: 770-909-6596 Attn: Biometric Screening - ATL

UFCW Unions & Employers H&W Fund - Atlanta
THE FUND OFFICE
1740 Phoenix Parkway
Atlanta, Georgia 30349

NOTE: The **Biometric Screening Program** is for eligible employees only. While we encourage your dependents to obtain their routine preventive care, they do not need to complete a screening.

UFCW UNIONS & EMPLOYERS HEALTH & WELFARE FUND - ATLANTA

2019 BIOMETRIC SCREENING RESULT FORM

PARTICIPANT INFORMATION SECTION

AUTHORIZATION & RELEASE OF INFORMATION - By providing the information below and submitting this Biometric Screening Result Form, I acknowledge and agree to the following Terms and Conditions: This form must be fully completed and legible to be processed. Date of screening should be between January 1, 2019 and September 30, 2019. I hereby authorize the medical health care provider and/or medical facility listed below to release the following health data to the United Food and Commercial Workers Unions and Employers Health and Welfare Fund - Atlanta. The Fund shall protect this health data in the same manner as it protects other health data it receives.

SIGNATURE: [Signature Box] DATE: [M M D D Y Y Y Y]

PLEASE USE ALL CAPS - ONE LETTER/NUMBER PER BOX

FIRST NAME: [First Name Boxes]

LAST NAME: [Last Name Boxes]

SOCIAL SECURITY NUMBER: [Last 4 numbers of SS#]

DATE OF BIRTH: [M M D D Y Y Y Y] GENDER (M/F): [Gender Box]

BIOMETRIC MEASUREMENTS AND PHYSICIAN INFORMATION

BMI (kg/m2): [BMI Boxes] BLOOD PRESSURE: [Systolic/diastolic Boxes]

BLOOD GLUCOSE (mg/dL): [Glucose Boxes] FASTING? (Y/N): [Fasting Box]

LDL CHOLESTEROL (mg/dL): [LDL Boxes] DATE OF SCREENING: [M M D D Y Y Y Y]

PCP FIRST NAME: [PCP First Name Boxes]

PCP LAST NAME: [PCP Last Name Boxes]

PCP TITLE/LICENSURE: [PCP Title Box] PCP PHONE #: [PCP Phone Boxes]

PCP SIGNATURE: [PCP Signature Box]

FAX THIS FORM TO 770-909-6596 OR MAIL TO: UFCW UNIONS & EMPLOYERS H&W FUND - ATLANTA, 1740 Phoenix Parkway, Atlanta, Georgia 30349 Please be sure to retain a copy of your completed form for your records.