HealthCheck360

PHYSICIAN WELLNESS SCREENING

CAI's wellness program provides quick and easy opportunities to improve your long-term wellness while earning incentives. You are able to participate in a wellness screening through your physician. Please complete the following steps to ensure your screening results are received and approved by 10/28/2022.

How do I schedule?

- Contact your Healthcare Provider and schedule an annual wellness appointment
- Visits/lab work from 01/01/2022 to 10/28/2022 will be accepted

What should I bring to my appointment?

- Download the "Physician Wellness Screening" form from your www.myHealthCheck360.com account
    - Complete the "Participant" section before your appointment
    - You must sign your results form. Your results will not be processed without your signature.
- Healthcare Provider instructions (included on the next page)

How should I prepare for my screening?

- Fast 8-12 hours before your appointment
    - Speak with your physician if you have concerns about fasting
- Drink plenty of water
- Continue taking any prescribed medications
- Avoid strenuous activity

How do I submit my Physician Wellness Screening Form?

- Log in to www.myHealthCheck360.com
- Go to "My Program" tab and select "Physician Form"
- Fill in all required fields and upload a copy of your form
- Once submitted, you will receive a notification that results are under review

When can I review my results?

- Your results are available within 10 business days after they are received on myHealthCheck360. If your results are not available within 10 business days, please confirm that all required fields were included.

If you have any questions about your results or next steps, contact HealthCheck360 at 1-866-511-0360 or support@HealthCheck360.com

PLEASE PROVIDE YOUR PHYSICIAN THE FOLLOWING INSTRUCTIONS:

ATTENTION HEALTH CARE PROVIDER:

Your patient is a participant in a health and wellness program sponsored through their employer. Please return the attached "Physician Wellness Screening" form to your patient as soon as results are processed.

PLEASE COMPLETE THE FOLLOWING:

- Ensure the patient has completed and **signed** the participant section on the results form.
- Collect the biometric measurements, blood specimen and complete the remaining sections of the results consent form by following the instructions below.
- Return the completed form to your patient.
- Please ensure services are coded as preventative, not diagnostic.
- Submit invoices to the address on the patient's Health Insurance Card.

PLEASE USE THE GUIDELINES BELOW WHEN COLLECTING MEASUREMENTS:

- **Height**: Perform the height measurement using a sliding height measuring stick. Have the patient remove their shoes and record to the nearest ¼ inch. Self-reported heights are not acceptable.
- **Weight:** Perform a weight measurement using a professional grade scale with a minimum capacity of 400 pounds. Have the patient remove their shoes and record. Do not make any adjustments for clothes.
- **Waist:** Use a soft tape measure. For waist measurement, place the tape measure at the navel. Record to the nearest ¼ inch. .
- **Blood Pressure:** Perform using a standard sphygmomanometer, cuff size as appropriate. If the initial reading exceeds 120/80, retake on opposite arm and document result in 2nd blood pressure field.

HealthCheck360 Contact Information:

Email: Support@HealthCheck360.com

Phone: 866-511-0360

Fax: 563-587-5720

HealthCheck360

PHYSICIAN WELLNESS SCREENING RESULTS FORM

Upload to your myHealthCheck360.com account by: 10/28/22
Only lab results from 01/01/22 to 10/28/22 will be accepted.

PARTICIPANT INFORMATION (COMPLETED BY PATIENT – PLEASE PRINT)

EMPLOYER NAME: Computer Aid

LOCATION CODE: CAINC

UNIQUE ID:

PHONE NUMBER: ___-___-____

EMPLOYEE (P) / SPOUSE (D): ___ P ___ D

PREGNANT: ___ Y ___ N

LEGAL LAST NAME:

LEGAL FIRST NAME:

SEX: ___ M ___ F

DATE OF BIRTH: __/__/____

EMAIL ADDRESS:

ADDRESS:

CITY:

STATE:

ZIP:

PARTICIPANT SIGNATURE: _____ **DATE:** _____

RELEASE OF HEALTH INFORMATION: By submitting this form, I am requesting my physician to report my biometric and laboratory results to HealthCheck360 to be included as part of an employer sponsored wellness program. By signing below, I authorize the release of my personal health information and preventive health screening results listed on this form by my health care provider. This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification. I understand that all fields must be completed in order for my form to be accepted.

REQUIRED TO PROCESS RESULTS

HEIGHT (INCHES) ___ INCHES

WEIGHT (LBS.)

WAIST (INCHES)

BLOOD PRESSURE ___/___

BLOOD PRESSURE (IF 1ST > 120/80) ___/___

LAB DATE __/__/__

TOTAL CHOLESTEROL

HDL

LDL

TRIGLYCERIDES

GLUCOSE

EXAMINATION DATE __/__/__

DOES PATIENT SMOKE, USE TOBACCO PRODUCTS OR NICOTINE SUBSTITUTES? ___ Y ___ N

PHYSICIAN INFORMATION

Your patient is a participant in a health and wellness program sponsored program through their employer or spouse's employer. Through this wellness program, your patient has an opportunity to improve their health risks as they exhibit healthy lifestyle choices. This program is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning.

PHYSICIAN CLINIC:

PHONE NUMBER: ___-___-____

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____

Email: Support@HealthCheck360.com | Phone: 866-511-0360 | Fax: 563-587-5720