



**GEORGIA STATE HEALTH BENEFIT PLAN (SHBP)  
WELLNESS PLAN**



**Biometric Screening - Physician Reporting Form**

For physician biometric screenings completed from 7/1/2011 through 6/30/2012

**2012 WELLNESS Plan Requirements:**

SHBP members (including covered spouses) who have enrolled in a 2012 WELLNESS Plan Option have agreed to the WELLNESS Promise, which is their agreement to:

- 1) Complete Cigna's online Health Assessment between January 1, 2012, and June 30, 2012; and
- 2) Obtain an approved biometric screening between July 1, 2011, and June 30, 2012.

The approved biometric screening requirement can be satisfied by participating in a SHBP sponsored worksite screening event or completing a biometric screening during an office visit or as part of an annual preventive examination.

Results from SHBP sponsored worksite screening events are automatically transferred to the SHBP administrator, and SHBP members may log in to the secure personal health record maintained by Cigna to see the results.

Results from biometric screenings provided by physicians must be faxed from the physician's office to SHBP administrator, Cigna, using the attached form. The physician must complete all of the biometric screenings identified on the attached form, record the results of the screenings on the form, and, per the instructions provided below, sign and submit the completed form to Cigna by June 30, 2012. Timely submission of the properly completed form will satisfy the biometrics screening portion of the WELLNESS Promise. [These results must be submitted by the physician, as self-reporting by the Member or spouse will not meet the requirements of the WELLNESS Promise.]

All results submitted to the SHBP as fulfillment of the SHBP WELLNESS Promise are protected by law, as described in the SHBP Notice of Privacy Practices.

**INSTRUCTIONS FOR SHBP PARTICIPANT**

Complete SECTION 1 of the FAX form including signature AND present the form to your physician at your scheduled appointment. Instruct the physician to complete the required information and fax the form directly to Cigna at 860.256.6767.

If you have already completed a screening (since June 1, 2011) you may take the completed form to your physician and request completion of SECTION 2 with your results and submission of the form.

Remember, your annual preventive care is covered at 100% if provided by an in-network physician. This means you are not responsible for a copay or coinsurance. Talk to your physician about using one of the following codes to make sure your visit is processed correctly.

99385 - New, Ages 18-39

99395 - Established, Ages 18-39

99386 - New, Ages 40-64

99396 - Established, Ages 40-64

99387 - New, Ages 65 & over

99397 - Established, Ages 65 & over

**COMPLETED FORMS MUST BE RECEIVED BY JUNE 30, 2012 TO QUALIFY**

**INSTRUCTIONS FOR PHYSICIAN**

Complete SECTION 2 of the FAX Form and fax to Cigna at 860.256.6767

Fasting results are not required but may be submitted if available.

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**2012 State Health Benefit Plan (SHBP)  
Biometric Screening - PHYSICIAN FAX FORM  
Fax to Cigna at - 860.256.6767**



Dear Physician,

I am participating in the GA SHBP WELLNESS Plan. As a requirement of this plan I have agreed to complete a biometric screening with the results to be submitted to SHBP as detailed on the previous page. Please complete SECTION 2 below and fax the completed and signed form to the Cigna e-fax line no later than June 30, 2012.

Thank you.

**SECTION 1: PATIENT INFORMATION (PATIENT - Complete this section. Please print)**

<b>First Name</b>				<b>Last Name</b>			
<b>Street Address</b>			<b>City</b>		<b>State</b>		<b>Zip</b>
<b>Phone Number :</b> (    )				<b>Insurance (Cigna) ID #</b>			
<b>Check Gender:</b>		<input type="checkbox"/> <b>Male</b>		<input type="checkbox"/> <b>Female</b>		<b>Age:</b>	
						<b>Date of Birth:</b>	
				<b>Month/</b>		<b>Date/</b>	<b>Year</b>

**Please read the following disclosure statement:** I understand that the collection of my health screening data is a requirement of participation in the SHBP WELLNESS Plan and my medical information will be submitted to Cigna and SHBP and remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge that I am voluntarily participating in this health screening.

**SIGNATURE** **DATE**

*PATIENTS: Biometric Screenings must be completed and submitted by **JUNE 30, 2012.** If you have questions or need additional assistance, please call the number on your Cigna ID card.*

**SECTION 2: PATIENT BIOMETRIC VALUES (PHYSICIAN - Complete this section for the above patient. Please print)**

**Required Screening Information**

<b>Exam Date</b> _____ / _____ / _____ <i>Month Day Year</i>	<b>Height</b> _____ <i>Feet</i> _____ <i>Inches</i>	<b>Total Cholesterol:</b> _____ mg/dl
<b>Weight</b> _____ <i>pounds</i> _____ <i>BMI</i>	<b>HDL Cholesterol:</b> _____ mg/dl	
<b>Blood Pressure</b> _____ / _____ mmHg	<b>LDL Cholesterol:</b> _____ mg/dl	
<b>Glucose:</b> <input type="checkbox"/> <b>Fasting</b> _____ mg/dl	<b>OR</b>	
<input type="checkbox"/> <b>NonFasting</b> _____ mg/dl		

<b>PROVIDER's Name</b> _____		<b>Phone Number :</b> (    )	
<i>(Please Print)</i>			
<b>First</b> _____		<b>Last</b> _____	
<b>FAX Number :</b> (    )			
<b>Street Address</b>		<b>City</b>	
		<b>State</b>	
		<b>Zip</b>	

**PROVIDER'S SIGNATURE** **DATE**

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