

SCREENING NAME

2021 City of Memphis Biometric Screening

CRITERIA AND INSTRUCTIONS

The following testing criteria must be met for the participant to be eligible for the wellness program.

1. The required fasting laboratory tests include: **Lipid Panel and Fasting Glucose.**
2. The required biometrics include: **Blood Pressure, Height, Weight and Waist Circumference.**
3. **All biometric and lab test results must be provided on this form.**
4. Do not provide a copy of this form to other participants. Each participant must request their own form.
5. Tests should be administered no earlier or later than what is required by your employer.
6. It is your responsibility to ensure the form is completed and sent in.
7. You may submit your form by either of the following options:
 - a. Email your completed form to ehs.physicianscreening@ehealthscreenings.com
 - b. Fax your completed form to 210-767-2245

Section A | PARTICIPANT INFORMATION (participant to complete)

First Name:		Last Name:	
Sex:	Subscriber ID: <small>9 numbers minus the first three characters from BCBS ID card</small>	DOB: (mm/dd/yyyy): _____ / _____ / _____	
Phone:		Email:	
Participant Signature:			Date:

Section B | PHYSICIAN AND/OR TESTING FACILITY INFORMATION (physician / nurse to complete)

Physician & Practice / Facility Name:	
Address:	Phone#:
National Provider ID # or CLIA certification #:	Test Date (required): _____ / _____ / _____
Physician Signature:	Date:

Section C | BIOMETRIC TEST RESULTS AND FASTING STATUS (physician to complete)

Blood Pressure

Systolic: <small>(mmHg)</small>	Diastolic: <small>(mmHg)</small>
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Body Measurements

Height: <small>(inches)</small>	Weight: <small>(lbs)</small>	Waist: <small>(inches)</small>
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Fasting Status

<input type="checkbox"/> Yes, I fasted 9 or more hours
<input type="checkbox"/> No, I did not fast 9 or more hours

Section D | LAB TEST RESULTS (physician to complete)

Blood Testing Results

Total Cholesterol: <small>(mg/dl)</small>	LDL Cholesterol: <small>(mg/dl)</small>	HDL Cholesterol: <small>(mg/dl)</small>	Triglycerides: <small>(mg/dl)</small>	Glucose: <small>(mg/dl)</small>			
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Health Screen Program - Employee Notice and Authorization

Your employer has contracted with BCBST on behalf of Premise Health Employer Solutions, LLC, and its affiliate eHealthScreenings ("Premise Health") to provide certain health and/or wellness services in connection with voluntary health screen program.

If applicable, by participating in the biometric screening, you consent to the collection of a blood specimen and/or bodily fluids. You understand and acknowledge that the collection of blood through a needle or fingerstick may cause pain, a bruise or, rarely, an infection. You also consent to the collection of additional biometrics (height, weight, blood pressure, waist circumference, and perhaps other measurements, as per the design of the program). You understand that a biometric screening is not meant to replace the care of a medical professional and that Premise Health may recommend that you seek additional medical care based on the screening.

Protection of Your Health Information: Premise Health agrees to abide by all applicable laws and regulations governing the privacy and security of your personal health information. To the extent Premise Health is subject to the Health Insurance Portability and Accountability Act and its implementing regulations ("HIPAA"), Premise Health will abide by HIPAA and maintain the privacy and security of your Protected Health Information ("PHI") in accordance with your employer's Notice of Privacy Practices ("Notice") and your employer's directive. You may request a copy of this Notice from your employer.

Authorization: I understand that my participation in the program is strictly voluntary, and in order to determine my eligibility for follow-up, the administrator(s) of the health and wellness program must receive a record of my participation. By signing below, I authorize Premise Health will disclose information regarding my participation in the program with the administrator(s) of the program. If the program includes by design a review of my results (e.g., measurement, test or blood specimen results) so that I can be provided recommendations in furtherance of my health, I authorize Premise Health to disclose my results to any third party who has contracted with my employer to review and analyze those results in connection with the program. I understand that no information obtained or created as a result of my participation in this program will be used to make any employment decision about me.

I understand that this information may be disclosed through electronic means unless some other method of disclosure is specified in this authorization. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Effective Time: This authorization will expire five (5) years from date of signature.

Right to Revoke Authorization: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to Premise Health, Compliance Department, 5500 Maryland Way, Suite 120, Brentwood, TN 37027. Premise Health will forward your revocation notice to your employer. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation or any actions that are legally permissible without my specific authorization or permission, including uses and disclosures permitted under HIPAA. I further understand that my revocation of this authorization may impact my ability to participate in the screening program.

Signature and Copy: I have read this form in its entirety and voluntarily consent to the HRA collection and biometrics procedures. I agree to the consent to the uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge the participant is at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

(Participant – Please Print):

First Name: _____ Last Name: _____

Email: _____ DOB (Month/Day/Year): _____

Subscriber ID (9 numbers minus the first three characters from BCBST card): _____

Participant or Legal Representative Signature: _____ Date: _____

Screening Key: TNB26

Please submit with your completed physician screening form.