



## 2021 Biometric Health Screening Provider Form

Dear Physician/Provider:

I am participating in The Ohio State University health and well-being program, Your Plan for Health (YP4H). I have agreed to complete a biometric health screening. These numbers are needed to earn additional incentives and will need to be provided to The Ohio State University Health Plan, Inc. (OSUHP). Please complete Section 2 below and send the completed and signed form to the OSUHP via fax at **(614) 688-9670** or send via secure email to [yp4h.clinicalservices@osumc.edu](mailto:yp4h.clinicalservices@osumc.edu)

*Please Note: It may take up to 30 calendar days for this form to be processed by OSUHP and Virgin Pulse. Biometrics must have been measured during this calendar year to be considered. Incomplete forms will not be processed.*

**SECTION 1: TO BE COMPLETED BY YOU, THE MEMBER (Please Print)**

<b>Last Name</b>	<b>First Name (Legal Name)</b>
<b>Birth Date (MM/DD/YYYY)</b>	<b>Best way to reach you to confirm form is processed, please include both phone &amp; email:</b>
	<input type="checkbox"/> Phone: (____) _____
	<input type="checkbox"/> Email: _____

**Please read and sign the following disclosure statement:** I understand that my biometric screening data will be released to The Ohio State University Health Plan, Inc. for the purposes of follow-up health education and disease management, data aggregation for program improvement purposes, and/or for the purposes of updating my Personal Health and Well-being Assessment. I understand the collection of my health screening data is voluntary and my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA).

**Participant/Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN/PROVIDER**

Exam Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Gender:    Male      Female

Height: _____ Feet    _____ Inches	Blood Pressure: _____ / _____ mmHg
Weight: _____ Pounds	Pulse: _____
BMI: _____      Pregnant:    Y / N / NA	

**BLOOD PANEL**

<b>CHOLESTEROL</b>	<b>GLUCOSE or A1C (required)</b>
Total Cholesterol: _____ mg/dl	Fasting Status: <input type="checkbox"/> Fasting
HDL: _____ mg/dl	<input type="checkbox"/> Non-Fasting
	Blood Glucose: _____ <b>OR</b> A1C: _____

Physician/ Provider's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Physician/ Provider's Name (Please Print): \_\_\_\_\_  
 Office Phone number: (      ) \_\_\_\_\_ Address: \_\_\_\_\_

**All fields are required. Please submit the completed form to the OSU Health Plan:  
 Fax: (614) 688-9670 or secure email to [yp4h.clinicalservices@osumc.edu](mailto:yp4h.clinicalservices@osumc.edu)  
 Forms will be accepted until 5:00 PM on December 30, 2021**

Upon completion of processing, an email confirmation will be sent to the email address above from [yp4h.clinicalservices@osumc.edu](mailto:yp4h.clinicalservices@osumc.edu)