THE OHIO STATE UNIVERSITY
HEALTH PLAN

Biometric Health Screening Form

Dear Primary Care Provider (PCP):

I am participating in the Ohio State University Health Plan (OSUHP). As a requirement upon benefit enrollment election, I have agreed to complete a biometric health screening. These numbers are needed to complete my Personal Health & Well-Being Assessment (PHA) and will need to be provided to OSUHP to earn an incentive. Please complete Section 2 below and fax the completed and signed form to OSUHP by September 30, 2015.

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

Last Name ______________________ **First Name** (Legal Name) ______________________

Birth Date (MM/DD/YYYY) ____________

Best way to reach you with questions:

Phone: (_____) ____________________

Email: ____________________________

Please read and sign the following disclosure statement: I understand that my biometric screening data will be released to OSUHP 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 online PHA. 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 (HIPPA).

I further understand that this completed form must be received by OSUHP **no later than 11:59 PM on September 30, 2015** in order to apply for the benefit open enrollment period that begins in October 2015 for the 2016 calendar year.

Signature: ______________________________ **Date**: ______________

SECTION 2: TO BE COMPLETED BY YOUR PCP / PHYSICIAN

Exam Date: _______/______/______ Gender: Male Female

Height: _______ Feet _______ Inches

Weight: ________ Pounds

BMI:__________ Pregnant: Y / N

Blood Pressure: ______/______mmHg

Pulse: ________

BLOOD PANEL

CHOLESTEROL

Total Cholesterol: ___________ mg/dl

HDL: ___________ mg/dl

GLUCOSE

Fasting Status: ☐ Fasting ☐ Non-Fasting

Blood Glucose: _________________

A1c: __________________________

Physician/ Provider's Signature: ______________________________ Date: ______________

Physician/ Provider's Name (Please Print): ______________________________

Office Phone number: ( ) ________________ Address: ______________________________

Please fax completed form to OSU Health Plan at (614) 292-2667 by 09/30/2015