HII – Know Your Numbers PROVIDER Health Screening Form

BOTH PAGES MUST BE TURNED IN TO RECEIVE CREDIT.

EMPLOYEE INSTRUCTIONS

STEP 1 Fill out the top portion of this form and take it to your medical provider to be completed.

PRINT NAME

DATE OF BIRTH ____/____/____

DIVISION

- ☐ INGALLS SHIPBUILDING
- ☐ MISSION TECHNOLOGIES
- ☐ NEWPORT NEWS SHIPBUILDING

EMAIL ADDRESS

PHONE NUMBER

Would you be interested in receiving additional information about QuadMed Wellness resources available to you? ☐ YES ☐ NO

STEP 2 Turn in **both pages** of your completed form. You may:

- Fax it to 414-622-3802
- Drop it off at your local HII Family Health Center
- Mail it to your local HII Family Health Center: →

HII Family Health Center – NNS
Attn: Know Your Numbers
4500 Washington Ave.
Newport News, VA 23607
757-327-4169

HII Family Health Center – Ingalls
Attn: Know Your Numbers
2105 Old Spanish Trail
Gautier, MS 39553
228-205-7687

QUADMED MUST RECEIVE BOTH PAGES BY 03/31/2023. *Please allow 7 to 10 days for processing.*

STEP 3 Complete your online Wellness Profile.

- Visit **myquadmed.com/hii** to log in to or sign up for a MyChart account.
- Once logged in, access **Wellness Online** to complete your online wellness profile.
- All questions must be answered to complete the wellness profile and earn credit toward your incentive.
- For step-by-step instructions, visit **myquadmed.com/kyn**

MEDICAL PROVIDER INSTRUCTIONS

Your patient has the opportunity to earn a medical insurance discount. Please provide the following results.

All components must be completed for your patient to earn the incentive. No fields should be left blank. Substitutions for the below metrics will not be accepted. Tests must be administered between 5/1/22 and 3/31/23 to be eligible for the incentive.

NOTE TO PROVIDER:

A1C IS REQUIRED and **MUST BE** included on this form. There are no substitutes. Please use CPT code: 83036.

DATE TESTS ADMINISTERED ____/____/____

FASTING? ☐ YES ☐ NO

HEIGHT

WEIGHT

BODY MASS INDEX (BMI)

BLOOD PRESSURE

TOTAL CHOLESTEROL

HDL CHOLESTEROL

TRIGLYCERIDES

LDL CHOLESTEROL

HEMOGLOBIN A1C *(NOT GLUCOSE)*

TOBACCO USER? ☐ YES ☐ NO

PRINT PROVIDER NAME (OR PROVIDER STAMP)

PROVIDER SIGNATURE

PROVIDER PHONE NUMBER

QUADMED USE ONLY: MRN | Date Received ____/____/____ | Date Entered ____/____/____ | Entered by

QuadMed

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
WELLNESS PROGRAM SERVICES

I understand that Wellness Program services include health and wellness individualized counseling and/or biometric screening services and related programming, and that some or all of this information is my legally protected health information ("PHI"). I authorize verbal and written release of my Wellness Program information to my health plan, health care vendor for health plan related purposes, and/or data analytics vendor for health care operations and quality assessment purposes by or to Quad/Med, LLC and its representatives, agents, and associated providers ("QuadMed").

INFORMATION TO BE DISCLOSED:
The PHI disclosed pursuant to this authorization includes all Wellness Program related information and results, such as but not limited to, results of my tests, evaluations, diagnoses and medical history relevant to the tests and evaluations performed. This information includes such details as my height, weight, body mass index, cholesterol profile, blood pressure, glucose testing, blood panel, biometric screening results, health risk assessment results, tobacco use information, incentive program tracking information, or any other general information that QuadMed already maintains about me from health related services.

I understand the purpose of the use and/or disclosure authorized by this release is to conduct, administer, and evaluate the effectiveness and quality of the Wellness Program, health/disease management services, aggregate data for population health studies and overall health plan or provider improvement initiatives, health risk assessments, and/or benefit enrollment related to my participation in the health plan and/or my receipt of health related services.

MY RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
This Authorization is Voluntary. I understand this authorization is voluntary. Unless allowed by law, my refusal to sign this authorization will not affect my ability to receive treatment from QuadMed or associated health care providers. I also understand my refusal to sign this authorization will not affect my eligibility for or ability to enroll in my employer's health plan benefits. However, I understand that certain of the benefits of the Wellness Program, such as incentive rewards, may not be available to me without a signed authorization, as applicable. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.

Right to Revoke this Authorization. I understand that I have the right to revoke this authorization at any time. My revocation will not apply to uses and disclosures that have already occurred under this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to QuadMed, Attention: Privacy Officer, N64W23110 Main Street, Sussex, WI 53089.

Right to Inspect and Copy. I understand that I have a right to inspect or obtain a copy of the PHI I have authorized to be used and/or disclosed by this authorization.

Right to Receive a Copy of this Authorization. If I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of this form.

Expiration. This authorization expires one (1) year from the date of my signature below.

I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes and that I authorize QuadMed to use and disclose my PHI in accordance with the terms and conditions above.

Print Name	Date	DOB
_____	_____	_____

_____
Signature of Participant or Personal Representative