HII Provider Health Screening Form

PAGES 2, 3 AND 4 MUST BE RETURNED TO RECEIVE CREDIT

Take all pages of this form to your medical provider when you go for your health screening. Once completed by your provider, it is YOUR responsibility to return this form to QuadMed, an affiliate of HII that manages the screenings for HII. Please allow seven to ten days for processing.

HEALTH PLAN PARTICIPANT

The screening follows the guidelines of preventative care under healthcare reform. Please note that we've provided guidelines on the right to help your provider understand what the screening should entail and what the plan will cover at 100% when you see an in-network provider. Copays or co-insurance should not apply. Understand that if you see an out-of-network provider or if your provider orders additional tests outside these guidelines, they may not be covered and you will be responsible for additional costs.

About your privacy

Your health screening and health check survey information is maintained securely and confidentially by QuadMed, a third-party vendor who operates the BeWell for Life wellness program and the HII Family Health Centers. All personal information is protected by HIPAA (Health Insurance Portability and Accountability Act) and is not shared with HII. Medical information from your health screening and health check survey goes directly to QuadMed. QuadMed then works with Alight, HII's benefits administrator, to ensure you receive the discount on your medical premium for the start of the benefit plan year.

About tobacco use

Employees enrolled in an HII medical plan are eligible for the Tobacco Free Incentive Program. Through the program, employees who declare they are "tobacco-free" receive a preferred, tobacco-free rate on their medical insurance. Employees who declare they are tobacco users receive the standard rate on their insurance. Employees are able to declare if they are tobacco-free or are tobacco users during Annual Enrollment.

When completed, return pages 2 and 3 of your completed form. You may:

– Fax it to 414-622-3802, OR

– Drop it off OR mail it to a HII Family Health Center:

HII Family Health Center
Attn: Know Your Numbers
4500 Washington Ave.
Newport News, VA 23607

HII Family Health Center
Attn: Know Your Numbers
2105 Old Spanish Trail
Gautier, MS 39553

MEDICAL PROVIDER

Your patient is completing a biometric health screening to be eligible for lower medical plan premiums. Please read through this form for details on what should be reviewed during your patient's health screening and then, when the screening is complete, please fill out this form, sign and date it and return it to the patient.

ATTENTION PROVIDER: **Please fill out page 2 completely. All screening components MUST be completed for your patient to earn the incentive. No fields can be left blank. Substitutions for any metric will NOT be accepted. Hemoglobin A1c (CPT code 83036) is REQUIRED and MUST be included on the form. A health screening visit should be coded as preventive to ensure no cost to the patient. The health screening must be administered between 5/1/23 and 3/31/24 to be eligible for the incentive.**

About the screening

This screening follows the guidelines of preventative care under the Affordable Care Act. The second page outlines what biometrics are required.

Please make your patient aware of what, if anything, you are ordering outside of the screening guidelines. Claims will be paid in accordance with our health plan and your patient may be charged out-of-pocket costs.

If you have any questions, please contact the Know Your Numbers hotline at 757-327-4169.

BeWell FOR LIFE
Operated by QuadMed

HII – Know Your Numbers PROVIDER Health Screening Form

PAGES 2, 3 AND 4 MUST BE RETURNED 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.

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DATE OF BIRTH _____

PHONE NUMBER _____ PATIENT EMAIL _____

DIVISION

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

Are you interested in receiving additional information about the HII wellness resources available to you? ☐ **YES** ☐ **NO**

STEP 2 Turn in **pages 2 and 3** of your completed form. You may:

- Fax it to 414-622-3802
- Drop it off **OR** mail it to a HII Family Health Center: →

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

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

QUADMED MUST RECEIVE BOTH PAGES BY 03/31/2024. *Please allow 7 to 10 days for processing.*

STEP 3 Complete your online Health Check Survey.

- 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 health check survey.
- All questions must be answered to complete the health check survey 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 can be left blank. Substitutions for the below metrics will not be accepted. Biometric health screenings must be administered between 5/1/23 and 3/31/24 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 (IN INCHES) _____ WEIGHT _____

BODY MASS INDEX (BMI) _____ BLOOD PRESSURE _____

TOTAL CHOLESTEROL _____ HDL CHOLESTEROL _____

TRIGLYCERIDES _____ LDL CHOLESTEROL _____

HEMOGLOBIN A1C *(NOT GLUCOSE)* USE CPT 83036 _____ TOBACCO USER? ☐ YES ☐ NO

PRINT PROVIDER NAME (OR PROVIDER STAMP) _____

PROVIDER SIGNATURE _____ PROVIDER PHONE NUMBER _____

BeWell FOR LIFE
Operated 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.

Participant Name	**Date**	**DOB**	**Employer**

Signature of Participant or Personal Representative	**Relationship to Participant (Legal Authority)**

For internal use only:
MRN _____