

STATE HEALTH BENEFIT PLAN (SHBP) WELLNESS PLAN OPTIONS

PROVIDER NOTIFICATION FORM

For Health Actions Completed 7/1/2011 - 6/30/2012

Important Information

The *UnitedHealth Personal RewardsSM* program rewards SHBP members enrolled in wellness plan options for taking steps to help maintain good health or to achieve greater health. One important step for members is completing a biometric screening. Knowing their biometric numbers may help members identify risks for many serious health conditions that develop over time. By working with their doctor or a wellness coach to make healthy changes, these health conditions may be delayed or prevented.

Instructions for Completion of this Provider Notification Form

INSTRUCTIONS FOR MEMBERS: Please complete the Member Information section of this form prior to meeting with your doctor. Please have your physician complete, sign and fax (or mail) side two of this form to **Provider Action Form** as noted on the bottom of page 2.

Your Health Actions must be completed by June 30, 2012, in order to qualify for rewards. This form will be processed within 10 business days from receipt as long as all required information is submitted. If you have questions regarding this form or the program, please call the number on the back of your UnitedHealthcare member ID card.

INSTRUCTIONS FOR PROVIDERS/CLINICS: Please use side two of this form to report a member's biometric result(s).
Note: Only physicians can report results and exceptions for members.

INSTRUCTIONS FOR PHYSICIANS: Please indicate date of service and, if applicable, test results on side two of this form. Please fax (or mail) signed, side two of this form to **Provider Action Form** as noted on the bottom of page 2 by June 30, 2012.

Please note: If it is unreasonably difficult due to a medical condition (for example, pregnancy, etc.) for a member to be tested for biometric marker's, or if it is medically inadvisable for them to do so, you may grant the member an Exception on side two of this form.

Please note: Biometric values recommended by nationally recognized medical associations were taken into consideration to establish the biometric standards of this program, but the standards may differ from the recommendations of these associations and may also be different from biometric targets recommended for a member by their doctor. The standards of this program are not intended to replace the care plan designed for a member by their doctor.

Member Information (Required. Name and ID number must exactly match what's listed on your UnitedHealthcare Medical Plan ID card.)			
Member Identification Number		Group Identification Number 702030	
Member Last Name	First Name	Middle Initial	Date of Birth
Address — Number and Street		City	State Zip Code
Phone		Email	
Member Signature			Date
Provider Information (required)			
Provider Name / Name of Clinic (please print)		Phone	FAX
Office Address — Number and Street		City	State Zip Code
Provider Signature (required)			
Provider Signature		TaxID	Date

Check Box on left for each health action being reported	Required Information	Exceptions (Physician Use Only)	Provider Initials
<input type="checkbox"/> Body Mass Index (BMI) biometric test Standard for BMI is <30 kg/m2 <i>Please note: Less than 18.5 is underweight, 18.5 – 24.9 is normal weight, 25 - 29.9 is overweight and 30.0+ is obese. We strongly encourage members who are underweight, overweight or obese to discuss this with their provider or participate in a wellness coaching program.</i>	Height (feet): _____ (inches): _____ Weight (lbs): _____ Date of Service: _____	<input type="checkbox"/> Member is exempt from submission of the test value due to a medical condition (such as pregnancy) or other health factor	
<input type="checkbox"/> * LDL Cholesterol biometric test Standard for LDL is <130 mg/dl	LDL: _____ Date of Service: _____	<input type="checkbox"/> Member is exempt from submission of the test value due to a medical condition (such as pregnancy) or other health factor	
<input type="checkbox"/> Blood Sugar biometric test Standard for Non fasting is < 200 and Fasting is <100	<input type="checkbox"/> Fasting <input type="checkbox"/> Non Fasting Blood Sugar: _____ Date of Service: _____	<input type="checkbox"/> Member is exempt from submission of the test value due to a medical condition (such as pregnancy) or other health factor	
<input type="checkbox"/> Blood Pressure biometric test Standard for blood pressure are systolic <140 and diastolic <90	Systolic: _____ Diastolic: _____ Date of Service: _____	<input type="checkbox"/> Member is exempt from submission of the test value due to a medical condition (such as pregnancy) or other health factor	

Health Action information entered by provider requires the provider's initials for each Health Action as well a signature on this form.

* This test should be Fasting test. Fast for 8 hrs, no food or drink. Water only.

Please submit this form and any required documents to: Provider Action Form, PO Box 8209 Kingston, NY 12402
 Or fax to 1-877-669-9860. IT IS ONLY NECESSARY TO FAX THIS SIDE OF THE FORM. Please submit a separate fax for each member.

