UnitedHealth Personal Rewards
A UnitedHealthcare Program

UnitedHealthcare

STATE HEALTH BENEFIT PLAN (SHBP) WELLNESS PLAN OPTIONS

UnitedHealthcare

PROVIDER NOTIFICATION FORM

For Biometric Screenings Completed 7/1/2011 - 6/30/2012

Important Information

The UnitedHealthcare SHBP Wellness Plan Options (powered by *UnitedHealth Personal Rewards*[SM]) encourage enrolled members to take steps to help maintain good health or to achieve better 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.

SHBP members (including covered spouses) who have enrolled in a UnitedHealthcare 2012 WELLNESS Plan Option and have agreed to the WELLNESS Promise, which is their agreement to: 1) Complete UnitedHealthcare's online Health Assessment between January 1, 2012, and June 30, 2012; and 2) Obtain an approved biometric screening between July 1, 2011, and June 30, 2012. The approved biometric screening requirement can be satisfied by participating in a SHBP sponsored worksite screening event or as part of a physician's examination. Results from SHBP sponsored worksite screening events are automatically transferred to the SHBP administrator, and SHBP members may log in to their secure personal health record maintained by UnitedHealthcare at www.MYUHC.com to view their results as well as access them through their online personal scorecard by registering at https://uhcrewards.healthinsight.com/shbp.

Results from biometric screenings provided by physicians should be faxed from the physician's office to the SHBP administrator; UnitedHealthcare, using this form. The physician must complete and record all of the biometric screenings listed on the form and, per the instructions provided below, sign and submit the completed form to UnitedHealthcare by June 30, 2012. Timely submission of the properly completed form will satisfy the biometric screening portion of the WELLNESS Promise. [These results must be submitted by the physician, as self-reporting by the Member or spouse will not meet the requirements of the WELLNESS Promise.] All results submitted to the SHBP as fulfillment of the SHBP WELLNESS Promise are protected by law, as described in the SHBP Notice of Privacy Practices.

Instructions for Completion of this Provider Notification Form

INSTRUCTIONS FOR PATIENTS: Please complete the Patient 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 completed form must be submitted by June 30, 2012, in order to satisfy the biometric screening component of your WELLNESS Promise. This form will be processed within 30 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 patient's biometric result(s).
Note*: Only physicians can report results* to the SHBP administrator, UnitedHealthcare.

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.

2012 Wellness Promise requirements apply to the member and covered spouse only. (The 2012 Wellness Promise requirements do not apply to dependent children)

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.

Patient Information (Required - Member id number and patient name must match what's listed on your UnitedHealthcare Medical Plan ID card.)				
Member ID Number			**Group Identification Number** 702030	
Patient Last Name	**First Name**	**Middle Initial**	**Date of Birth**	
Address — Number and Street	City	State	Zip Code	
Phone	Email			
Patient 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)		
Physician Signature	TaxID	Date

	Check Box on left for each health action being reported	Required Information	[1]Provider Initials
☐	**Body Mass Index (BMI) biometric test** Standard for BMI is <30 kg/m2 *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.*	**Height (feet):**______ **(inches):**______ **Weight (lbs):** ______ **Date of Service:**________________	
☐	* **LDL Cholesterol biometric test** Standard for LDL is <130 mg/dl	**LDL:** _______ **Date of Service:** ______________	
☐	**Blood Sugar biometric test** Standard for Non fasting is < 200 and Fasting is <100	☐ **Fasting** ☐ **Non Fasting** **Blood Sugar:** _______ **Date of Service:** _____________	
☐	**Blood Pressure biometric test** Standard for blood pressure are systolic <140 and diastolic <90	**Systolic:** ______ **Diastolic:** ______ **Date of Service:** ____________	

[1] Health Action information entered by provider requires the provider's initials for each Health Action and a signature on this form.

* This test should be a 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 patient.