Public Education Employees'
Health Insurance Program

HEALTHCARE PROVIDER SCREENING FORM

ADPH Wellness Program
201 Monroe Street, Suite 986
Montgomery, AL 36104
Fax: 1-334-206-0385

Prior Authorization (Must complete before the Screening): I have read the Notice Regarding Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

Participant Signature

SECTION 1: (To Be Completed by Active or Retired Employee or Spouse) **PRINT CLEARLY WITH A BLACK INK PEN.** **DARKEN BOXES COMPLETELY.**

PEEHIP PID:

Patient SSN: (required) ___ – ___ – ____

☐ Male ☐ Female ☐ Contract Holder ☐ Spouse

Screen Date: __ – __ – ____

Birth Date: __ – __ – ____

Zip Code:

Last Name:

First Name:

Screening not performed due to: ☐ Pregnancy ☐ Disability

What best describes your race/ethnicity?

- ☐ White
- ☐ Hispanic / Latino
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ Asian
- ☐ Other
- ☐ Native American / Alaska Native

Do you have (or have you been told you had) any of the following?

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

Do you take any medication for any of the following?

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

SECTION 2: (To Be Completed by Provider)

Blood Pressure: ___ / ___

Total Cholesterol: ___ mg/dl

HDL Cholesterol: ___ mg/dl

LDL Cholesterol: ___ mg/dl

Triglycerides ___ mg/dl

Blood Glucose: ___ mg/dl

Height: __ ft __ in

Weight: ___ lbs

Waist: ___ . __ in

Waist-To-Height Ratio __ **BMI:** __

Has the patient used a tobacco product or electronic smoking device in the last 12 months? ☐ Yes ☐ No

CLAIMS FILING INSTRUCTIONS FOR COPAYMENT WAIVER: Only one routine office visit is covered per calendar year under the PEEHIP benefits. No copayment is required for one annual preventive routine office visit obtained through an in-network provider (not applicable if a diagnosis associated with the visit). File the claim for the member's office visit with BC/BS for PEEHIP Group #14000. Use the appropriate CPT code for the office visit in order to be reimbursed at 100% of the allowable fee. The patient will be responsible for any other applicable copays, such as lab tests. The copay waiver is not allowed at Urgent Care Centers or Emergency Rooms. Incomplete forms will not be processed.

Healthcare Provider Name (Please Print)

Healthcare Provider Signature

Healthcare Provider Type (Please Print)

Healthcare Provider Address & Phone Number (Please Print)

TEAM UP FOR HEALTH

PEEHIP

ALABAMA PUBLIC HEALTH

Please FAX or mail to the **ADPH Wellness Program.**