Public Education Employees' Health Insurance Program
PHARMACY BIOMETRIC SCREENING AND REFERRAL FORM

Screening Date: ☐☐/☐☐/☐☐☐☐

Pharmacy Name: _____ Pharmacy Location:_____

PEEHIP Member Name: _____

Prior Authorization (Must complete before the Screening): I have read the enclosed 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 and in other Wellness Program requirements 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

PEEHIP Member ID (contract number on Medical ID card): ☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Email Address: _____@_____

Employee		**Spouse**		**Retiree**		**Age**		**Gender**	M / F

Does the patient have or has the patient ever been told they have any of the following conditions? (Mark all that apply)

____ High Cholesterol ____ High Blood Pressure____ Diabetes

Does the patient take medication for any of the following? (Mark all that apply)

____ High Cholesterol____ High Blood Pressure____ Diabetes

Screening Data

Category Abnormal range	**Results**	**Abnormal?**	**Category** Abnormal range	**Results**	**Abnormal?**
Blood Pressure Systolic >= 160 mm HG or Diastolic >= 100 mm Hg	**/**	**Y / N**	**Blood Glucose** >= 200 mg/dl	**mg/dl**	**Y / N**
Total Cholesterol >= 250 mg/dl	**mg/dl**	**Y / N**	**Height**	**Ft In**	
HDL Cholesterol	**mg/dl**	**Y / N**	**Weight**	**lbs**	
LDL Cholesterol	**mg/dl**	**Y / N**	**BMI** >= 40		**Y / N**
Triglycerides	**mg/dl**	**Y / N**			

Were any screening values abnormal? _____ Yes _____ No
Was the patient referred to his/her healthcare provider for follow up? _____ Yes _____ No

By signing below, I acknowledge that I provided the patient with a copy of the applicable Employer / Health Plan sponsored Wellness Program form(s). Prior to the screening, the patient reviewed the Notice Regarding Wellness Program, confirmed that they understood the policies and procedures set out in the Notice, gave voluntary authorization to proceed with the screening, and instructed me to record their authorization herein. I further acknowledge that I counseled the patient regarding any risks associated with the screening results on this form.

Pharmacist Signature _____

Office Visit Referral (voluntary if applicable)

☐ *Due to abnormal test results and/or certain identified risk factors indicated above, the patient has been referred to their Primary Care or other Physician for further evaluation.* ***Patient should take this form with them to their office visit. The referral visit is voluntary.***

CLAIMS FILING INSTRUCTIONS: *File the claim for the office visit with BC/BS for PEEHIP Group #14000. Use appropriate CPT code for the office visit and* ***be sure to include modifier "KX"*** *in order to be reimbursed 100% of the allowable fee.* ***THIS REFERRAL IS ONLY GOOD FOR 60 DAYS FROM THE SCREENING DATE ABOVE AND ONLY COVERS THE COPAYMENT FOR THE VISIT.***

COPAYMENT WAIVER: This patient's office visit copayment has been waived and should not be collected*. The patient will be responsible for any other applicable copays, such as lab tests. Only one referral is allowed during the plan's screening period. Please follow normal billing procedures for subsequent visits.*

Notice Regarding Wellness Program

(For use with the Pharmacy Biometric Screening Form)

The PEEHIP wellness program is a voluntary wellness program available to all PEEHIP subscribers and covered spouses who are enrolled in PEEHIP's Hospital Medical PPO Plan (Group #14000) administered by *Blue Cross and Blue Shield of Alabama.* The program is administered according to federal rules permitting employer sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete a wellness screening. The wellness screening will measure your biometric values including blood pressure, height, weight, and body mass index (BMI). A blood sample will also be taken to measure glucose, cholesterol, and triglycerides. You are not required to participate in the wellness program. However, members who choose to participate in the wellness program and complete a wellness screening by the annual August 31 deadline will receive an incentive in the form of a $50 monthly waiver of the wellness premium for the entire plan year.

If you are unable to obtain a wellness screening due to pregnancy, disability, or other infirmity, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting PEEHIP at 877.517.0020.

The results from your wellness screening will be used to provide you with information to help you understand your current health and potential risks. The results may also be used to offer you services through the wellness program, such as health coaching and/or disease management coaching. You are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the PEEHIP wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, PEEHIP will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) nurses, doctors, health coaches, and staff from PEEHIP and our business associates in order to provide you with services under the wellness program.

PEEHIP and its business associates are required by federal law to comply with certain privacy and security requirements. This means, for example, that all medical information obtained through the wellness program will be transmitted and stored in a secure manner as required by law, and no information you provide as part of the wellness program will be used in making any employment decision or in making any decision about your eligibility to enroll in PEEHIP. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the PEEHIP Section 1557 Coordinator at 877.517.0020.