Health Risk Screening

MVP Health Care® has partnered with American Specialty Health Management to offer the Healthyroads wellness program. The Healthyroads program includes health risk screenings. If you wish to participate in the Healthyroads health risk screening, please read the instructions below.

Instructions for Member

1. Contact your doctor's office to schedule a preventive health visit and have a health care provider validate your screening results by entering your screening results in Section 2 of the form on Page 2, and signing the form. Or, if you have been screened within the past 24 months and have evidence of your screening results (i.e., a copy of your medical record), you can enter your screening results in Section 2 of the form on Page 2 yourself and include that documentation when you submit the screening form.
2. Make a copy of the completed form for your records.
3. Submit the completed form on Page 2 using one of the methods below.
   Email: **MVPforms@ashn.com**
   Fax: **855-318-2746**
   Mail: MVP REWARDS, ATTN: BIO DATA-C4-1, PO BOX 509040, SAN DIEGO CA 92150-9040

Forms must be received on or before **December 31, 2018**. Please allow up to four weeks for Health Risk Screening form processing.

Participant Attestation/Authorization:

As part of a voluntary wellness program, you will also be asked to complete a voluntary biometric assessment test, which will include a blood test for general screening purposes. The biometric assessment test will not gather any genetic information of the participant, except to the degree health information about an employee's spouse is considered genetic information of the employee under the Genetic Information Nondisclosure Act of 2008 ("GINA"). American Specialty Health Management, Inc. (provider of the Healthyroads program) and its affiliates or subsidiaries as well as their successors, assignees, and licensees (hereinafter "ASH Management") may use and/or provide the information relating to the biometric assessment tests to your plan sponsor or health plan, or to other entities that have contracted with your plan sponsor or health plan, as applicable, to administer your plan. In addition, ASH Management may also use your personal information obtained through the biometric assessment results form to provide you with information about other health-related benefits available to you through your plan sponsor or health plan, as applicable. That data may also be used to populate your online tools on Healthyroads.com, which may be used by your Healthyroads Coach® in connection with the Healthyroads Coaching Program if that program is available to you and you choose to participate in it. Provision of the information noted above to your plan sponsor, health plan, or other entities, as applicable, and for health coach outreach to the phone number you provide that have contracted with your plan sponsor or health plan to administer your plan, is intended for purposes related to treatment, payment (billing, eligibility) or operational and administrative requirements. Such purposes will vary by entity, but may include, eligibility for incentives due to participation in the program, quality control and auditing purposes, and facilitation with case management or disease management programs available from your plan sponsor or health plan, as applicable. In these situations, ASH Management requires recipients of the information to ensure that there are safeguards in place so that personal information is only used for the purposes noted. If information is disclosed to plan sponsors who are employers, then such information is required to be used for benefit administration purposes only. 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. Your employer or plan sponsor cannot deny you access to health coverage or have the extent of your benefits limited, or subject you to any other adverse employment action or retaliation, for not participating.

Health Risk Screening

Please print legibly. Incomplete or illegible forms cannot be processed. ***Indicates required information.**

Section 1: Information About Yourself *(please print)*

*Member Name, exactly as it appears on your MVP Member ID card *(First, Last)*

*MVP Member ID No.

*Date of Birth

Phone No.
( )

Email Address

By signing below I certify that the information provided is complete and accurate. I authorize MVP Health Care or American Specialty Health to contact my provider to validate the information on this form. I understand that my employer may not be required to protect the information that is the subject of this authorization. The information submitted will be uploaded to my MVP online wellness record.

I am aware that if I would like to request additional information about how my individual data will be used, I may contact the MVP Wellness Team at **wellnessprogram@mvphealthcare.com**. I may revoke this authorization at any time by providing written direction to MVP.

I confirm I have read and agree to this and the Participant Attestation/Authorization on Page 1.

*Member Signature

Date

Instructions for Health Practitioner

Please provide all of the results below marked with an asterisk. Sign, date, and return this form to your patient.

If your patient is requesting a re-measure of certain values, please provide only the result for those values and the date they were re-measured.

Section 2: Screening Information *(to be completed by Health Practitioner or Member)*

*The screening results indicated below are the patient's *(check one)*: ☐ Initial Screening ☐ An Update Submission

*Fasting? ☐ Yes ☐ No

*Screening Date:

*Weight: lbs.

*Height: ft. in.

*Blood Pressure: / mmHG

*Tobacco use *(including electronic smoking devices)* within 90 days? ☐ Yes ☐ No

*Total Cholesterol: mg/dL

*HDL: mg/dL

*Total Cholesterol/HDL Ratio:

*Fasting Blood Sugar: mg/dL

OR

*HbA1c: %

***I verify that my patient is up to date on all age and gender-appropriate screenings and immunizations. ☐ Yes ☐ No**

*Health Care Practitioner Signature *(or office stamp)*

*Date

Practitioner Name

Practitioner Phone No.