Instructions for Screening With Your Healthcare Provider

As an employee of XYZ Company, you have the opportunity to participate in your company's wellness program, administered by Bravo. This program rewards healthy lifestyle choices and participation is easy!

Please complete the steps below to ensure the results of your health screening are received by Bravo by November 1, 2020.

1. **Make an appointment now with your healthcare provider** to ensure there is enough time for you to be seen, and your lab work processed and returned. Make sure the provider you see is in your benefit plan network or you may incur an additional personal expense. Most health plans cover one preventative wellness visit a year at 100 percent, with no out-of-pocket costs for you. Remind your provider that the screening should be coded as a "preventative care" visit. Please note: a second health screening performed in the same calendar year will not be covered at 100 percent.

   If you've had a health screening conducted between January 1, 2020 and today, your results may be used to fulfill the requirement. ***Please have your healthcare provider fill out the enclosed provider screening form, including his/her signature, license number and phone number.*** *When complete, return it to Bravo.*

2. **Complete the participant section of the enclosed provider screening form. Please do not share your form with another participant. It is uniquely coded with your personal information.** Read the statements under PARTICIPANT ATTESTATION AND SIGNATURE, then sign the bottom of the form. The remainder of the form is for the provider to fill out.

3. **Remember to fast for 10 to 12 hours prior to your appointment and drink plenty of water.**

4. **This information is time-sensitive and must be complete (with supporting documentation),** signed by your healthcare provider, with the appropriate information completed, and received by Bravo by November 1, 2020 in order to participate in the program. An incomplete form may result in nonparticipation status.

Bravo will contact you to confirm all documentation has been received. Questions? Let's talk. Call 844.275.6698.

Upload, fax, or mail your completed and signed forms to Bravo.

Fax: 877.410.1913

Mail: 20445 Emerald Parkway Dr. SW, Suite 400 Cleveland, Ohio 44135

bravo®

PROVIDER SCREENING FORM

Do NOT share your form, it is uniquely coded with your personal information.

PATIENT INFORMATION:

FORM DUE DATE: November 1, 2020
Previous screening results will be accepted if collected on or after: January 1, 2020

Last Name: LastName First Name: FirstName

DOB: DOB Eligibility ID #: AcctNbr Gender: Gender

FOR PRIMARY CARE PROVIDER USE ONLY— ALL SECTIONS OF FORM MUST BE COMPLETED

Waist Measurement ____ In ○ 1/4 ○ 1/2 ○ 3/4

Height ____ Ft ____ In ○ 1/4 ○ 1/2 ○ 3/4 Weight ____ lbs

Blood Pressure ____ / ____ (Systolic) (Diastolic)

Total Cholesterol ____ Triglycerides ____

HDL Cholesterol ____ LDL Cholesterol ____

Fasting Blood Glucose ____

PHYSICAL CONFIRMATION

Does your patient have a history of coronary artery disease? (MI, CABG, PTCA)

○ Yes ○ No

Does your patient have a history of diabetes?

○ Yes ○ No

If no, does your patient have pre-diabetes?

○ Yes ○ No

Is your patient current on recommended cancer screenings?

○ Yes ○ No

Does your patient exercise weekly? If so, how many times per week?

○ 0-1 ○ 2-4 ○ 5 or more

PRIMARY CARE PROVIDER SIGNATURE

○ This patient is under my care for a condition that makes participation in the wellness program medically inadvisable. I hereby certify that this participant should be given the full credit available for program participation and will maintain monitoring under my continued care.

Provider Signature:_____ **Date of Exam:** ____ (Month) ____ (Day) ____ (Year)

Printed Name:_____ **License #:**_____ **Phone #:**_____

Once the form is complete with signature, date of exam and license number, please return to the patient for submission.

PARTICIPANT ATTESTATION AND SIGNATURE

○ **Yes** ○ **No** **Have you used tobacco/nicotine products or substitutes within the past 90 days?**

Tobacco/nicotine products and substitutes include but not limited to: *cigarettes, electronic cigarettes, cigars, pipe smoking, snuff, chewing tobacco, nicotine patch, gum, lozenge, and other supplements.*

I hereby certify that the information included in this form is accurate to the best of my knowledge and I authorize this data to be provided to Bravo Wellness, LLC for the purpose of administering my employer's wellness program. (Refer to your Program Guide for privacy notice.)

Participant Signature:_____ **Printed Name:**_____

Upon obtaining your primary care provider's signature, please sign and return this form to Bravo Wellness, LLC for confidential tracking. The validity of this signature may be verified for authenticity. Falsification of information will be subject to disciplinary actions consistent with employee guidelines up to and including employment termination. If you have any questions, please speak with your Human Resources representative.

You are responsible for submitting a completed form to Bravo by the due date above. Do not return this form to your employer.
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Mail: **20445 Emerald Parkway Dr. SW, Suite 400 Cleveland, Ohio 44135**

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Form ID: LPREVATT