LVHN My Total Health Incentive Program
2021 ANNUAL PRIMARY CARE VISIT FORM

Wellness Participant Information and Consent

As a colleague of Lehigh Valley Health Network (LVHN), I understand that LVHN manages an employer sponsored wellness program in partnership with BeneFIT Corporate Wellness, as an added benefit to help improve and/or manage wellness. As a result, there are certain incentive activities that are available, which require the collection of specific biometric and laboratory results (specified on this form in Section 2), the completion of this form through collaboration with my physician, as well as a number of other predefined activities, as identified on the My Total Health portal. In order to meet the Annual Primary Care Visit activity, this form must be completed and returned by **November 30, 2021.**

I understand that the completion of this form and/or participation in the My Total Health Incentive Program (Program) is completely voluntary. I also understand that the completion and submission of this form (along with my signature) constitutes my acknowledgment to participate in the Program and, as such, I give my express permission to have my physician prescribe and report my laboratory and biometric results (required for the Program) to BeneFIT Corporate Wellness. As a result of my participation in the Program, I understand that:

- **I AM responsible** for adhering to the timeframes for completing the necessary biometric/laboratory tests and/or scheduling appointments with my physician in order to meet the incentive requirement for the My Total Health Incentive Program.
- **I AM responsible** for ensuring that my physician completes and returns the form prior to the deadline so that it can be submitted to BeneFIT Corporate Wellness for processing.
- **I AM responsible** for any copays, deductibles or other out of pocket expenses as a result of any visits with my physician, forms that my physician needs to complete, and/or laboratory tests that are performed in order to meet the requirements for the My Total Health Incentive Program.
- **NO individualized** biometric or laboratory test results will be shared with LVHN. Identifiable biometric or laboratory test information is only available to those with a business need to know at BeneFIT for purposes of managing the components of the Program.

Section 1: Participant Information (completed by colleague) – Please Print

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Phone Number: _____ **Gender:** _____ **Date of Birth:** _____ **LVHN SUI:** _____

PARTICIPANT SIGNATURE: _____ **DATE:** _____

Section 2: Provider Information (completed by provider) – Please Print

FAX COMPLETED FORM to BeneFIT Corporate Wellness at 484-664-7680

Your patient, as identified in Section 1, is a participant in an employer sponsored wellness program at Lehigh Valley Health Network in partnership with BeneFIT Corporate Wellness. This program is not intended to treat, diagnose, or replace physician involvement, but rather to support primary care and prevention by encouraging employees to visit their primary care physician regularly. Please prescribe the appropriate lab tests and complete the section below for the above participant/patient. Once complete and signed, please return the form to BeneFIT via one of the options identified above in the heading of Section 2 no later than **November 30, 2021.**

Healthcare Provider/Clinic Name: _____ **Phone Number:** _____

Provider Address: _____

CHOLESTEROL

Total Cholesterol ☐☐☐
HDL Cholesterol ☐☐☐
LDL Cholesterol ☐☐☐
Triglycerides ☐☐☐
Fasting ☐ YES ☐ NO
Date of Test ☐☐ / ☐☐ / ☐☐

GLUCOSE (BLOOD SUGAR)

Total Blood Glucose ☐☐☐
Fasting ☐ YES ☐ NO
Date of Test ☐☐ / ☐☐ / ☐☐

BLOOD PRESSURE

Systolic ☐☐☐ /
Diastolic ☐☐☐ HR ☐☐☐
Date of Test ☐☐ / ☐☐ / ☐☐

BODY COMPOSITION

Height ☐ Ft ☐☐ In BMI ☐☐ Waist Circumference ☐☐ In Hip Circumference ☐☐ In
Weight ☐☐☐ Lbs Body Fat ☐☐ % Date of Test ☐☐ / ☐☐ / ☐☐

PROVIDER SIGNATURE: _____ **DATE:** _____

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