



StayWell Health Care Provider Form

Employee Section

- Take this form to your participating BCBS Provider to record your height, weight, blood pressure, glucose, total cholesterol, and HDL. The results will be added to your confidential Personal Health Questionnaire.
- Return the fully completed, signed form to StayWell before **December 1, 2008**. Failure to provide this completed form to StayWell by December 1, 2008 will result in you only receiving 40% of the Nissan financial contribution for 2009. **Mail to: StayWell Health Management Attn: DPC
PO Box 21427
St. Paul, MN 55121**
- Questions? Call StayWell at 1-888-388-8256 or Nissan HR Service Center at 1-866-599-4647 (1-866-59WINHR)

First Name		Last Name	
Employee ID		Date of Birth	
BlueCross BlueShield of Tennessee Member ID (located on membership identification card)			

Please print. All information above is required to ensure your screening results are recorded for your incentive and the medical claim is fully covered.

Consent to Use Information. I understand that StayWell Health Management may use information obtained from this voluntary health screening to provide health management services to me, which includes using this information to inform me of relevant health improvement programs offered by StayWell or by another service provider engaged by StayWell or my employer. I understand that data analysis companies or StayWell and their respective agents and employees may use this information for group statistical analysis and to update my health information. I understand that my employee ID may be used only to identify my information and track my program participation.

I also understand that StayWell may provide information, such as my name and/or employee ID, to my employer or its designated representative to notify them of the fact that I have completed the program. I also understand that my employer will not receive my personal health information gathered through my participation in the health screening.

My signature authorizes StayWell to contact my health care provider listed above with any questions regarding my height, weight, blood pressure, glucose, total cholesterol, and HDL.

Employee Name (Print)

Employee Signature

Date

Provider Section

BCBS Physician		Provider Phone	
Date of Service			
Weight		Height	(ft) (in)
Blood Pressure	Systolic (top #)		Diastolic (bottom #)
Please check either <u>fasting</u> or <u>non-fasting</u>		<input type="checkbox"/> Fasting (8 hours or more)	<input type="checkbox"/> Non-fasting
Total Cholesterol			
HDL			
Glucose			

Physician Name (Print)

Physician Signature

Date