

Providence Health & Services Alaska

Health Care Provider Form

If you are benefits eligible under the Providence Health & Services Alaska ("Providence Alaska") benefits plans, you may submit biometric screening results from your health care provider to qualify for the 2011 health insurance premium credit.

Use this form to have your health care provider record your height, weight, blood pressure, total cholesterol, and HDL cholesterol. Please have your health care provider complete all information on the form and sign below. After having your health care provider sign, send this form to StayWell in order to receive your health insurance premium credit. You also must complete and submit the health assessment online or on paper to receive the credit. Go to <https://providencealaska.online.staywell.com> to complete the assessment online or call 800-971-0682 to request that a paper assessment be mailed to you.

Mail to:

StayWell Health Management
Attn: Screening Team
PO Box 21427
St. Paul, MN 55121

Secure Fax:

StayWell Health Management
Attn: Screening Team
1-877-637-4626
Please **do not** use a fax cover page

**It will take 15-18 business days for your biometric results to be included on your online health assessment.*

Providence Alaska				
First Name		Height	<small>Feet:</small>	
			<small>Inches:</small>	
Last Name		Weight		
Last 4 Digits of Social Security Number (SSN)		Body Mass Index		
Date of Birth <small>(MM/DD/YYYY)</small>		Blood Pressure		
Date measurements were collected <small>(MM/DD/YYYY)</small>	/ /	Total Cholesterol		
Fasting Status	<input type="checkbox"/> Fasting <input type="checkbox"/> Non-fasting	HDL		
		TC/HDL Ratio		
Tobacco Use	I have <u>not</u> used any tobacco product in the past 6 months (not one puff, dip or chew). <input type="checkbox"/> Have NOT used <input type="checkbox"/> Have used			
Health Care Provider Name				
Health Care Provider Signature				
Health Care Provider Phone				

Consent to Use Information. I understand that StayWell may use personally identifiable information obtained on this Health Care Provider Form, including, but not limited to, my name, the last four digits of my Social Security number (SSN), my date of birth, and my screening results (my "Personal Information") to provide health management services to me. These services include using the Personal Information to inform me of relevant health related and health education programs offered by StayWell or by another service contractor. In the event that StayWell's services are transitioned to another service provider, StayWell may disclose my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any health insurance premium incentives, StayWell may provide my name/last four digits of my SSN to Providence Alaska or its designated representative to notify them of the fact that I am eligible or not eligible for health insurance premium credit. Providence Alaska will only know who has met the incentive criteria, not the actual biometric values or programs individuals qualify for or are enrolled in with StayWell. In addition to any Personal Information disclosed as set forth above, aggregate survey results, without any individually identifiable Personal Information, may be made available to Providence Alaska for program reporting purposes. StayWell and other contracted data analysis companies may also use my Personal Information as part of group statistical research and analysis. I also understand that my information may be entered into my Health Assessment results by StayWell. Except for these types of usage and the uses specified in my StayWell Online terms of use, my Personal Information will not be disclosed by StayWell.

I certify that the information supplied on this form has been provided to me by my health care provider, and I understand that StayWell may contact my health care provider listed above with questions regarding my information. My signature authorizes StayWell to contact my health care provider listed above with any questions regarding my height, weight, blood pressure, total cholesterol, and HDL.

Participant Signature: _____

Date of Screening: _____

Questions? Call the StayWell HelpLine at 800-971-0682

