THE OHIO STATE UNIVERSITY
HEALTH PLAN

2023 Biometric Health Screening Form

Dear Physician/Provider:

I am participating in The Ohio State University health and well-being program, Your Plan for Health (YP4H). I have agreed to complete a biometric health screening. These numbers are needed to earn additional incentives and will need to be provided to The Ohio State University Health Plan, Inc. (OSUHP). Please complete Section 2 below and fax the completed and signed form to the OSUHP at ***(614) 688-9670***. Provider offices can also submit this form by using secure email functionality by emailing this completed document to **yp4h.clinicalservices@osumc.edu**

Please Note: It may take up to 30 calendar days for this form to be processed by OSUHP and Virgin Pulse.
Biometrics must have been measured during this calendar year to be considered. Incomplete forms will not be processed.

SECTION 1: TO BE COMPLETED BY YOU, THE MEMBER (Please Print)

_____ _____

Last Name*

First Name (Legal Name)*

_____

Birth Date (MM/DD/YYYY)*

Best way to reach you with questions, please include the following & check the preferred method to reach you:

- ☐ Phone: (_____) _____
- ☐ Email: _____

Please read and sign the following disclosure statement: I understand that my biometric screening data will be released to The Ohio State University Health Plan, Inc. for the purposes of follow-up health education and disease management, data aggregation for program improvement purposes, and/or for the purposes of updating my Personal Health and Well-being Assessment. I understand the collection of my health screening data is voluntary and my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA).

Participant/Patient Signature*:_____ **Date**: _____

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN/PROVIDER

Exam Date: _____/_____/_____ Patient Sex at Birth: Male Female

Height:_____Feet _____Inches Weight:_____Pounds BMI:_____ Pregnant: Y / N / NA	Blood Pressure:_____/_____mmHg Pulse: _____

BLOOD PANEL

CHOLESTEROL	GLUCOSE or A1C (required)
Total Cholesterol: _____ mg/dl HDL:_____mg/dl	Fasting Status: Fasting or Non-Fasting Blood Glucose:_____ **OR** A1C:_____

Physician/ Provider's Signature:_____Today's Date: _____
Physician/ Provider's Name (Please Print): _____
Office Phone number: ( )_____Address: _____

All fields are required. Please submit the completed form to the OSU Health Plan:
Fax: (614) 688-9670 or secure email to yp4h.clinicalservices@osumc.edu
Forms will be accepted until 5:00 PM on December 20, 2023 for YP4H points
Forms will be accepted until 11:59 PM on December 31, 2023 for OSUHP premium credit

Last updated 1/23/2023