THE OHIO STATE UNIVERSITY
HEALTH PLAN

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). Biometric health screening 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/secure email the completed and signed form to the OSUHP at ***(614) 688-9670 or*** **yp4h.clinicalservices@osumc.edu.**

Please Note: It can take up to 30 calendar days for this form to be processed by OSUHP and Personify Health.
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 PHYSICIAN/PROVIDER

Physical Exam Date: _____/_____/_____

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	Fasting Status: Fasting or Non-Fasting
HDL:_____mg/dl	Blood Glucose: _____ **OR** A1C: _____
LDL:_____mg/dl *(optional)*	

Physician/ Provider's Signature: _____ Date: _____

Physician/ Provider's Name (Please Print or include stamp): _____

Office Phone number: _____ Address: _____

Physician/ Provider Stamp

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, 2025 for YP4H points. Forms will be accepted until 11:59 PM EST on December 31, 2025 to earn full premium credit for 2026.

Last updated 12/16/24