Wellness Exam - Female

Employee, Spouse, Child Age 19 and Over, and Retiree under Age 65

Who completes this Form: ALL Members regardless of age in order to qualify for the ULTIMATE, BEST or BETTER health plan level.

Submit Form To: Your Insurance Coordinator

***NOTE* Qualifying Events are subject to audit which may result in a plan level change.**

Participant Name: ☐ Employee ☐ Dependent ☐ Retiree	**Date of Birth:**	**Age on 1/1/21:**
Email Address:	**Phone #:**	
Employee's Name:	**Employee ID#:**	

EXAMS & SCREENINGS (According to CDC, ACG, or USPSTF) Complete according to the age guidelines provided.

A "NO" RESPONSE ON 1-7 BELOW WILL RESULT IN BEING PLACED IN THE BASIC OR BETTER PLAN LEVEL!

The participant has completed the following exams/screenings:

1	Blueprint for Wellness Labs between 12/1/20 – 6/30/21	☐ **Yes** ☐ **No**
2	Preventive Physical Exam with Skin Screening between 9/1/20 – 8/31/21	☐ **Yes** ☐ **No**
3	Clinical Breast Exam between 9/1/20 – 8/31/21	☐ **Yes** ☐ **No**
4	Pelvic Exam between 9/1/20 – 8/31/21	☐ **Yes** ☐ **Not recommended by Dr**
5	Pap Smear in past 3 years *(age 21+ as of 1/1/21)*	☐ **Yes** ☐ **Not recommended by Dr**
6	Mammogram in past 2 years *(age 40-49)* or annually *(age 50+)* between 9/1/20 – 8/31/21	☐ **Yes** ☐ **No** *(leave blank if under age 40 as of 1/1/21)*
7	Colorectal Screening *(age 50 or older as of 1/1/20)*	☐**Yes** ☐ **No** *(leave blank if under age 50* as of 1/1/21). ***Please indicate which screening was completed:*** ☐ Colonoscopy in past 10 years ☐ Or, Cologuard (FIT-DNA stool test) in past 3 years ☐ Or, CT Colonography in past 5 years (*precertification required*)
8.	Does the participant have diabetes?	☐ **Yes** ☐ **No**
	If yes… Is participant newly diagnosed with diabetes? (since 6/1/19)	☐ **Yes** ☐ **No**
	Is participant a new enrollee with existing diabetes? (since 9/1/19)	☐ **Yes** ☐ **No**
	Has participant had an annual dilated eye exam by an ophthalmologist or optometrist?	☐ **Yes** ☐ **No**
	Has participant had an annual foot exam from primary care physician or endocrinologist?	☐ **Yes** ☐ **No**
	Has the participant completed all other diabetes qualifying criteria?	☐ **Yes** ☐ **No**
9.	Results of Cotinine Test	☐ **Positive** ☐ **Negative**

I attest that the information above is true and accurate to the best of my knowledge. I also acknowledge that if an audit reveals this information to be inaccurate, my plan level may be downgraded.

(Required) Participant Signature **Date**

Doctor signature no longer required

Keep a duplicate copy for your records

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