



Wellness Exam - Male

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

Who completes this Exam: 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:	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent <input type="checkbox"/> 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 1-4 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 9/1/20 – 6/30/21	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Preventive Physical Exam with Skin Screening between 9/1/20 – 8/31/21	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Testicular Exam between 9/1/20 – 8/31/21	<input type="checkbox"/> Yes <input type="checkbox"/> Not recommended
4.	Colorectal Screening	<input type="checkbox"/> Yes <input type="checkbox"/> No (leave blank if under age 50 as of 1/1/21). Please indicate which screening was completed: <input type="checkbox"/> Colonoscopy in past 10 years <input type="checkbox"/> Or, Cologuard (FIT-DNA stool test) in past 3 years <input type="checkbox"/> Or, CT Colonography in past 5 years (precertification required)
5.	Does the participant have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes...</i> Is participant newly diagnosed with diabetes? (since 6/1/19) <input type="checkbox"/> Yes <input type="checkbox"/> No Is participant a new enrollee with existing diabetes? (since 9/1/19) <input type="checkbox"/> Yes <input type="checkbox"/> No Has participant had an annual dilated eye exam by an ophthalmologist or optometrist? <input type="checkbox"/> Yes <input type="checkbox"/> No Has participant had an annual foot exam from primary care physician or endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the participant completed all other diabetes qualifying criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Results of Cotinine Test	<input type="checkbox"/> Positive <input type="checkbox"/> 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.