# Health Provider Preventive Screening Form

UnitedHealthcare®

PNF - CENTURYLINK

## Section 1 – PATIENT INFORMATION (PLEASE PRINT , and complete prior to visit)

**Identification Number *(CenturyLink Employee Number)*** | **Company Name.** CenturyLink (Waived Medical Coverage) -00005825

**Patient Last Name** | **First Name** | **Middle Initial** | **Date of Birth (mm/dd/yy)**

**Address — Number and Street** | **City** | **State** | **Zip Code**

### Patient Signature (Required) Receipt Deadline: 12/31/2014

By signing below, I give my healthcare provider permission to send this form to UnitedHealthcare.

By signing this form, I authorize my provider to disclose my preventive screening results to my wellness plan administrator for the purpose of administering my wellness benefits and incentive awards as applicable, and conducting other health plan activities as permitted by law. To the extent I am covered under an employer group policy which provides incentive awards related to a preventive screening program, I authorize my wellness plan administrator to disclose information regarding my participation in this screening event and eligibility for various incentive awards to the plan sponsor employer group for the purpose of administering any incentive awards.

I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. However, I understand that there may be certain wellness benefits (including incentive awards) through my employer that I will not be eligible for as a result of not participating in this program or not providing my preventive screrening results to my wellness plan administrator.

I understand that my health information may be subject to re-disclosure bty the recipient and that if the recipient is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation. Unless revoked earlier, this authorization will expire one year from the date of my signature.

**Patient Signature (required)**

SIGN HERE →

**Date: mm/dd/yy** | **Phone Number (area code) XXX-XXXX**

**EMAIL ADDRESS : (Required)**

**TO PATIENT:**
**Take this form to your doctor or clinic for your health screening. Complete the Patient Information prior to your appointment; your doctor or clinic staff will complete the remaining sections. The form needs to be submitted by mail or fax.**

## Section 2 – RESULTS

| Preventive Screening Measures | Complete information only for the measures being reported | Practitioner Section Physician Initials |
|---|---|---|
| **Annual Preventive Exam** One exam annually | Date of Service: _____ *mm / dd / yy* | Initial _____ |
| **Mammogram Screening** Females age 50+ every 2 years | Date of Service: _____ *mm / dd / yy* | Initial _____ |
| **Prostate Screening** | Date of Service: _____ *mm / dd / yy* | Initial _____ |
| **Colorectal cancer screening : Age 50+** Fecal Occult (every 3 years) Flexible Sigmoidoscopy (every 5 yrs) -or- Colonoscopy (every 10 yrs) | Date of Service: _____ *mm / dd / yy* | Initial _____ |
| **Cervical cancer screening** Females ages 21-29 every 2 years; 30-65 every 3 years | Date of Service: _____ *mm / dd / yy* | Initial _____ |

## Section 3 – PRACTITIONER INFORMATION

**Practitioner Name / Name of Clinic (please print)** | **Phone (incl. area code)** | **FAX**

**Office Address — Number and Street** | **City** | **State** | **Zip Code**

**Practitioner Signature (required)**

SIGN HERE →

**Tax ID** | **Date (mm/dd/yy)**

**TO CLINICAL PRACTITIONER:**
**Please use this form to report or give attestation of preventive medical services. Only complete the information for measures or services that are being reported for the patient. *Reported measures need to be initialed to qualify, and the form needs to be signed.* Thank you**

**MAIL OR FAX FORM AND ANY REQUIRED DOCUMENTS TO**:
Health Provider Preventive Screening Form, PO Box 8201, Kingston, NY 12402
Fax: (801) 994-1248