

## Local Government Health Insurance Board Provider Screening Form



**Prior Authorization (Must complete before the Screening)**

I have read the Notice Regarding Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

Participant Signature

**SECTION 1 (To Be Completed by Participant)**

**NOTE: The screening must be completed by October 31 and submitted to LGHIB no later than November 15.  
Incomplete forms will not be processed.**

Name (Please print)		Date of Screening	Male <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/>
			Female <input type="checkbox"/>	Age: _____
Insurance Number <b>LGB</b>	Group # <b>30000</b>	Last Four SSN #	Date of Birth	Day Time Phone Number (    )
Email				

**Do you have (or have you been told you had) any of the following? (Mark all that apply.)**

- High Cholesterol     
  High Blood Pressure     
  Diabetes     
  N/A

**Do you take Medication for any of the following? (Mark all that apply.)**

- High Cholesterol     
  High Blood Pressure     
  Diabetes     
  N/A

**SECTION 2 (To Be Completed by Provider)**

**NOTE: The requested labs below are the only labs considered for coverage if the participant is only being seen for an LGHIB wellness screening.**

- Complete screening deferred due to pregnancy or other physical limitation(s)

Blood Pressure _____ / _____ Total Cholesterol _____ mg/dL HDL Cholesterol _____ mg/dL LDL Cholesterol _____ mg/dL Triglycerides _____ mg/dL	Blood Glucose _____ mg/dL Height _____ ft. _____ in Weight _____ BMI _____
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**Provider's Name: (Please print)** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_

**Provider Phone Number:** \_\_\_\_\_

**Please return completed forms to:**

LGHIB WELLNESS  
PO BOX 304900  
MONTGOMERY, AL 36130-4900  
wellness@lghip.org

Phone: 1-866-836-9137, option 4  
Fax: (334) 851-6808

## LOCAL GOVERNMENT HEALTH INSURANCE BOARD WELLNESS PROGRAM PRIVACY NOTICE

The Local Government Health Insurance Board (LGHIB) Wellness Program is a voluntary wellness program available to certain local government employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

All active employees, non-Medicare retirees, and spouses, who are covered in group 30000, are eligible to participate in one worksite wellness screening during the wellness qualifying period.\* You can also have your wellness screening performed by your primary care physician; however, all applicable copayments will apply. Participating pharmacies will provide screenings at no charge. For a list of those pharmacies, go to [www.lghip.org](http://www.lghip.org).

If you choose to participate in the wellness program, you will be asked to complete a biometric screening, which will include a measurement of your blood pressure, height, weight, and waist size. Also, a blood sample will be taken to check your cholesterol, triglycerides, and glucose. You will also be asked whether you have or have had high cholesterol, high blood pressure, or diabetes and whether you take medicine for those conditions. The screening is intended to let you know whether you are at risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes. You are not required to participate in the wellness program and/or participate in the blood test or any other components of the biometric screening.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used by the LGHIB and our business associates to offer you services, such as wellness coaching and/or disease management coaching. You also are encouraged to share your results or concerns with your own doctor.

The LGHIB provides incentives to your employer if your employer meets certain wellness program participation percentages. Your employer may then choose to offer individual incentives for you to participate in the wellness program. However, your employer cannot deny access to health insurance or any package of health insurance benefits or retaliate against you due to your refusal to participate in the wellness program.

\*Wellness qualifying period information is located within the Wellness Program section of [www.lghip.org](http://www.lghip.org).

### Protections from Disclosure of Medical Information

The LGHIB and its business associates are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the LGHIB may use aggregate information the LGHIB collects to design a program based on identified health risks in the workplace, the LGHIB Wellness Program will not disclose your screening results either publicly or to your employer, except as expressly permitted by law. Medical information that personally identifies you, that is provided in connection with the wellness program, will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are nurses, doctors, health coaches and staff from the LGHIB and our business associates in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained by the LGHIB, separate from your employer's personnel records, and no information you provide as part of the wellness program may be used by your employer in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You cannot be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor will you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the LGHIB Privacy Officer at 334-851-6802.

**Please return completed forms to:**

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MONTGOMERY, AL 36130-4900  
[wellness@lghip.org](mailto:wellness@lghip.org)

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