WELLNESS SCREENING FORM

Use this form if you are seeing a health care professional for your wellness screening. You may report your wellness screening results by completing the Patient Information Section below and by having your doctor sign the completed form where indicated before returning the form to Cigna.

All sections on this form must be completed and the form must be signed by you and your physician or licensed medical professional.

Forms may be submitted by mail or fax

Mail: Cigna Customer Service
PO Box 5201-5201
Scranton, PA 18505

Fax: 1.877.916.5406
Enter on the fax cover sheet: "CONFIDENTIAL"

Patient Information Section (Please print all information)

Relationship: ○ Employee ○ Spouse/Domestic Partner ○ Dependent Gender ○ M ○ F

First Name | MI | Last Name

Street Address, Apt Number, P.O. Box

City | State | Zip

Cigna Account Number:

Primary Telephone
Area Code ( ) -

Social Security (SSN) Last 4 numbers
Note: Please use the last 4 digits of SSN for person being screened.

Customer ID (Note: located on your Cigna ID card; this is an 11 position field)

Patient Date of Birth
MM DD YYYY

Signature: By signing below you are confirming that the information on this form is true and accurate and that you understand that your screening data will be released to your Cigna health plan for the purpose of your qualification for these incentives

Today's Date
M M DD YYYY

Health Measurement Section (To be completed by Physician or Licensed Medical Professional)

Blood Pressure
Date _____
Systolic / Diastolic

Fasting Blood Sugar
Date _____
mg/dl

Total Cholesterol
Date _____
mg/dl

LDL Cholesterol
Date _____
mg/dl

BMI
Date _____
.

Height
Date _____
Feet Inches

Weight
Pounds

Physician (or Licensed Medical Professional) Information Section (Please print all information)

First Name | MI | Last Name

Address

City | State | Zip

Title

Signature of Physician or Licensed Medical Professional (Required)

Today's Date
MM / DD / YYYY

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Instructions for patients and health care professionals

The following instructions may be used by both patients and licensed medical professionals for completion of the Wellness screening form. The steps below guide you through completion of the form and how to submit the form to Cigna.

Patients

- Print a copy of the form and bring it with you to your physician visit, along with any Cigna health plan material you may have that outlines your incentive program.
- Please complete all fields in the top section including your name, address, birthdate, and account information.
- Please sign and date the form. Forms received without signature will not be processed.
- Please write clearly. Forms that are not legible may be returned.

Physicians (or Licensed Medical Professionals)

- When documenting biometric results, please include the biometric value and date the specific value was taken.
- Please sign and date the form.

If you have questions about completing this form please call the number on your Cigna ID card.
If you are not enrolled in a Cigna medical plan, please call 1-800-Cigna 24 (244.6224).

Your Privacy is Important: The privacy of your health information is important to you and to Cigna. We are committed to ensuring your personal health information is protected and secure, and that our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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