Healthyroads

Riverside Sheriffs' Association
Biometric Screening Health Care Provider Form

Riverside Sheriffs' Association Benefit Trust is encouraging all RSA Benefit Trust members and enrolled spouses to take an active role in managing their health by completing a biometric screening. You may use this form (if eligible) to submit your biometric screening results as completed by your health care provider to participate in the screening component of your incentive program. Please follow the instructions below to submit your results to the Healthyroads® program, provided by American Specialty Health Management, Inc. ("ASH Management").

INSTRUCTIONS:

1. Read the Use and Disclosure Statement at the bottom of page 1.
2. Complete Part 1 of the form using black or blue ink only. All fields marked with an asterisk are required.
3. Schedule and go to a preventive health visit with your health care provider (HCP) between **9/4/2017** and **7/4/2018**.
   a. All of the asterisked items in Part 2 should be completed as part of your visit.
4. Give this form to your provider and ask them to complete Part 2 and sign the form after writing in your screening results.
   a. You may be responsible for any charges relating to the completion of this form or office visits as billed by your provider.
   b. Laboratory reports should not be submitted. Laboratory reports will not be reviewed to obtain and process data values. Only data entered on this form by your HCP will be processed.
5. Make and keep a completed copy of this form for your records.
6. Send your form to the Healthyroads program by fax, email*, or mail. Forms must be received on or before **9/2/2018** to be eligible for your incentive program. Information will be treated in compliance with HIPAA Privacy and Security standards.
   - Fax Number: **1-877-495-2746**
   - Email Address: **ProviderReportedForms@ashn.com**
   - Mailing address: Healthyroads Program/RSA – Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040

   *Security measures available through email services can vary; because of this ASH Management encourages you to check with your email provider and/or organization about the security protections available to the emails you send before emailing your form.
7. Your results will be viewable on www.healthyroads.com under My Health→Scorecard within 10 business days of receiving your completed form. Your incentives program will also be updated at that time. Once your form has been processed, an email will be sent to you letting you know that your Scorecard has been updated on Healthyroads.com. (You must provide a valid email address to receive this notification) **If your form is incomplete, it will not be processed.**
8. If you have questions about this form, your incentive program, or Healthyroads services please contact Healthyroads Customer Service at 1-877-330-2746 or service@healthyroads.com.

Healthyroads Biometric Assessment Information Use and Disclosure Statement

As part of a voluntary wellness program, you will also be asked to complete a voluntary biometric assessment test, which will include a blood test for general screening purposes. The biometric assessment test will not gather any genetic information of the participant, except to the degree health information about an employee's spouse is considered genetic information of the employee under the Genetic Information Nondisclosure Act of 2008 ("GINA"). American Specialty Health Management, Inc. (provider of the Healthyroads program) and its affiliates or subsidiaries as well as their successors, assignees, and licensees (hereinafter "ASH Management") may use and/or provide the information relating to the biometric assessment tests to your plan sponsor or health plan, or to other entities that have contracted with your plan sponsor or health plan, as applicable, to administer your plan. In addition, ASH Management may also use your personal information obtained through the biometric assessment results form to provide you with information about other health-related benefits available to you through your plan sponsor or health plan, as applicable. That data may also be used to populate your online tools on Healthyroads.com, which may be used by your Healthyroads Coach® in connection with the Healthyroads Coaching Program if that program is available to you and you choose to participate in it. Provision of the information noted above to your plan sponsor, health plan, or other entities, as applicable, and for health coach outreach to the phone number you provide that have contracted with your plan sponsor or health plan to administer your plan, is intended for purposes related to treatment, payment (billing, eligibility) or operational and administrative requirements. Such purposes will vary by entity, but may include, eligibility for incentives due to participation in the program, quality control and auditing purposes, and facilitation with case management or disease management programs available from your plan sponsor or health plan, as applicable. In these situations, ASH Management requires recipients of the information to ensure that there are safeguards in place so that personal information is only used for the purposes noted. If information is disclosed to plan sponsors who are employers, then such information is required to be used for benefit administration purposes only. 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 or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Your employer or plan sponsor cannot deny you access to health coverage or have the extent of your benefits limited, or subject you to any other adverse employment action or retaliation, for not participating.

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Part 1 – To be completed by Participant

Please print legibly using black or blue ink ***only***. Incomplete or illegible forms will not be processed. Write your first and last name exactly the way that they appear on your payroll stub and/or your medical benefits card. **PLEASE NOTE: Values below with an asterisk (*) are *required*. This form will not be processed if any required values are missing**.

*First Name: *Last Name:

Employee Number: *Date of Birth (MM/DD/YYYY): / /

Email:

Phone Number:

May we use the email address we have on file or as provided on this form, to return your form to you if needed? ○ Yes ○ No

By marking Yes to the right, I authorize and invite American Specialty Health Management, Inc. (ASH Management) and its partners and affiliates to contact me regarding the benefits made available to me through my plan sponsor, including but not limited to the Healthyroads program, or for any other purpose, at any residential or cellular phone number that I provide now or in the future. I understand that calls or texts may be placed using automated telephone dialing equipment or an artificial or prerecorded voice, and that standard message and data rates may apply. I understand that I can call **1-877-330-2746** to unsubscribe from calls, and reply "STOP" to unsubscribe from text messages. I understand that my agreement to receive these calls or texts is not a condition of my participation in Healthyroads programs and services. ○ Yes ○ No

PARTICIPANT ATTESTATION/AUTHORIZATION: I authorize my information (completed by my provider in Part 2 of this form) to be disclosed to and used by ASH Management to help administer my employer-sponsored wellness program. I authorize ASH Management to contact my provider to validate the information on this form, if necessary as determined by ASH Management. I confirm I have read and agree to the Use and Disclosure Statement on page 1 of this form.

*Participant Signature: Date: / /

Part 2 – To be completed by Health Care Provider

Your patient's employer is encouraging all of its participants to take an active role in managing their health by completing a biometric screening between **9/4/2017** and **7/4/2018**. Please provide all of the results below marked with an asterisk, sign, date, and return this form to your patient.

*Date of Screening: / /

*Fasting? ○ Yes ○ No

Waist Circumference: in

*Weight: lbs

*Height: ft in

Please round to the nearest whole number

*Blood Pressure: / mmHG

Tobacco Use: ○ Yes ○ No

*Total Cholesterol (mg/dL):

*LDL (mg/dL):

*HDL (mg/dL):

*Triglycerides (mg/dL):

*Blood Glucose (mg/dL):

Hemoglobin A1c (%): .

Cotinine: ○ Positive ○ Negative ○ N/A

Health Care Provider Name: _____ NPI#:

*Health Care Provider Signature: Date: / /

Forms must be received by: 9/2/2018

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