HealthSCOPE BENEFITS

Please FAX this form to:

501-218-7941

The City of Fort Smith ARKANSAS

Health Screening Form: Employee or Spouse

Section 1:

Member Name: _____

Member Birth Date: _____

Member Social Security Number: _____

Member Phone Number: _____

Section 2:

Employee Social Security Number: _____

I agree to the release of the laboratory test results requested below from the provider to HealthSCOPE Benefits for the purpose of administering the City of Fort Smith's Wellness Program. I understand that I may be contacted regarding my results, but that any additional participation on my part after this contact is purely voluntary. I understand that I have a right to revoke this authorization in writing to the provider at any time, but the revocation will not apply to information that has already been released in response to this authorization.

Member Signature: _____

Health Screening Form: Provider

About the Wellness Program

The Wellness Program is available to employees and spouses enrolled in the City of Fort Smith Health Plan. Health screenings are an important part of the program, helping participants identify risk factors so they can take steps to reduce them. The Wellness Program is not meant to replace the medical advice of a physician.

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Please complete the following:

Lab Test	Result	Units	Test Date
Height		inches	
Weight		lbs	
Total Cholesterol		mg/dl	
HDL Cholesterol		mg/dl	
LDL Cholesterol		mg/dl	
Triglycerides		mg/dl	
Hemoglobin A1C		%	
Systolic Blood Pressure		mm Hg	
Diastolic Blood Pressure		mmHg	
Nicotine		ng/ml	

Provider Signature: _____

Provider Name (please print): _____

Provider Phone Number: _____

Clinic or Lab Name: _____