Hampton City Schools Wellness Program – Outside Provider Form

BOTH PAGES MUST BE RETURNED TO RECEIVE CREDIT

EMPLOYEE INSTRUCTIONS

STEP 1 Fill out the top portion of this form and take it to your medical provider to be completed. **Form must be legible in order to be processed.**

PATIENT FIRST NAME _____ PATIENT LAST NAME _____ DATE OF BIRTH _____

PHONE NUMBER _____ PATIENT EMAIL _____ - *Submitting your email address or submitting this form by email serves as your agreement to receive communications regarding this form via email from QuadMed on behalf of your health plan.*

STEP 2 Turn in **pages 1 and 2** of your completed form. You may:

- **EMAIL** to **HCSproviderforms@quadmedical.com**
  NOTE: *Form should be sent in PDF or JPG format only.*
- **FAX** to 414-622-3887
- **DROP OFF** at the Hampton City Schools Employee Health & Wellness Center
- **MAIL IT** to QuadMed
  Attn: HCS Biometrics
  N64 W23110 Main Street
  Sussex, WI 53089

QUADMED MUST RECEIVE BOTH PAGES BY 6/30/2026. *Please allow 10 days for processing.*

MEDICAL PROVIDER INSTRUCTIONS

Your patient has the opportunity to earn a medical insurance discount. All components must be completed (no blank fields) for your patient to earn the incentive.

Substitutions for the below metrics will not be accepted. Biometric health screenings must be administered between 7/1/25 and 6/30/26 to be eligible for the incentive.

NOTE TO PROVIDER:
A1C IS REQUIRED and **MUST BE** included on this form. There are no substitutions. Please use CPT code: 83036.

_____ FASTING? _____ _____ _____ _____
TESTING DATE ☐ YES ☐ NO HEIGHT (INCHES) WEIGHT WAIST CIRCUMFERENCE BLOOD PRESSURE

_____ _____ _____ _____
TOTAL CHOLESTEROL HDL CHOLESTEROL TRIGLYCERIDES LDL CHOLESTEROL

_____ TOBACCO USER? ☐ YES ☐ NO
HEMOGLOBIN A1C **(NOT GLUCOSE)**

_____
PRINT PROVIDER NAME (OR PROVIDER STAMP)

_____ _____
PROVIDER SIGNATURE PROVIDER PHONE NUMBER

QuadMed

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
WELLNESS PROGRAM SERVICES

I understand that Wellness Program services include health and wellness individualized counseling and/or biometric screening services and related programming, and that some or all of this information is my legally protected health information ("PHI"). I authorize verbal and written release of my Wellness Program information to my health plan, health care vendor for health plan related purposes, and/or data analytics vendor for health care operations and quality assessment purposes by or to Quad/Med, LLC and its representatives, agents, and associated providers ("QuadMed").

INFORMATION TO BE DISCLOSED:

The PHI disclosed pursuant to this authorization includes all Wellness Program related information and results, such as but not limited to, results of my tests, evaluations, diagnoses and medical history relevant to the tests and evaluations performed. This information includes such details as my height, weight, body mass index, cholesterol profile, blood pressure, glucose testing, blood panel, biometric screening results, health risk assessment results, tobacco use information, incentive program tracking information, or any other general information that QuadMed already maintains about me from health related services.

I understand the purpose of the use and/or disclosure authorized by this release is to conduct, administer, and evaluate the effectiveness and quality of the Wellness Program, health/disease management services, aggregate data for population health studies and overall health plan or provider improvement initiatives, health risk assessments, and/or benefit enrollment related to my participation in the health plan and/or my receipt of health related services.

MY RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

This Authorization is Voluntary. I understand this authorization is voluntary. Unless allowed by law, my refusal to sign this authorization will not affect my ability to receive treatment from QuadMed or associated health care providers. I also understand my refusal to sign this authorization will not affect my eligibility for or ability to enroll in my employer's health plan benefits. However, I understand that certain of the benefits of the Wellness Program, such as incentive rewards, may not be available to me without a signed authorization, as applicable. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.

Right to Revoke this Authorization. I understand that I have the right to revoke this authorization at any time. My revocation will not apply to uses and disclosures that have already occurred under this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to QuadMed, Attention: Privacy Officer, 555 S. 108th St., West Allis, WI 53214.

Right to Inspect and Copy. I understand that I have a right to inspect or obtain a copy of the PHI I have authorized to be used and/or disclosed by this authorization.

Right to Receive a Copy of this Authorization. If I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of this form.

Expiration. This authorization expires one (1) year from the date of my signature below.

NEW YORK RESIDENTS: If you are authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal and state law. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

I have had an opportunity to review and understand the content of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes and that I authorize QuadMed to use and disclose my PHI in accordance with the terms and conditions above.

Print Name	Date	DOB	Employer Name

Signature of Participant or Relationship to Participant

Personal Representative (Legal Authority)

For internal use only:
MRN_____