WELLNESS SCREENING FORM

Instructions for patients and health care professionals

- Print a copy of this form and bring it with you to the doctor's office.
- Fill out the Patient Information section. Answer every question. Form cannot be processed if incomplete.
- Your doctor, or other health care professional, should fill out the Wellness Screening Information section.
- Please be sure to write clearly, sign and date the form. Forms without a signature and date are incomplete.
- If you have any questions, call us using the phone number on the back of your Cigna ID card.

Marking instructions

A B C D E 1 2 3 4 5

Shade like this → ●
Not like this → ⊗ ✓

Forms may be sent by:

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

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

ONLINE: Electronically upload your form at myCigna.com

PATIENT INFORMATION

Relationship: Subscriber ○ Spouse/domestic partner ○ Dependent ○ Gender: Male ○ Female ○

Patient's First Name ______ MI ___ Patient's Last Name ______

Street Address, Apt Number, PO Box ______

City ______ State ___ Zip ______

Patient Date of Birth MM ___ DD ___ YYYY ______

Preferred Telephone Number ______ Is this a home ○ or cell ○ number?

Social Security (SSN) Last 4 numbers ______ *Note: Please use the last 4 digits of patient's SSN*

Patient's Cigna ID Number on ID card ______

Cigna Group Account Number on ID card 3 3 2 1 8 3 6

Customer Signature (required). My signature means that the information on this form is correct. ______ Today's Date MM ___ / DD ___ / YYYY ______

I understand that Cigna receives this information, and may use for determining my eligibility for incentives when applicable.

WELLNESS SCREENING INFORMATION

Date MM ___ / DD ___ / YYYY ______

BMI ___ . ___

Height/weight *(required)* Feet ___ Inches ___ Pounds ___

Waist circumference Inches ___

Blood pressure Systolic ___ Diastolic ___

Fasting blood sugar mg/dl ___ **OR** **Non-fasting blood sugar** mg/dl ___

Total cholesterol mg/dl ___

LDL cholesterol mg/dl ___

HDL cholesterol mg/dl ___

Health Care Professional/Doctor First Name ______ MI ___ Health Care Professional/Doctor Last Name ______

City ______ State ___ Zip ______

Signature of Health Care Professional/Doctor (required) ______ Today's Date MM ___ / DD ___ / YYYY ______

Your Privacy is important: The privacy of your health information is important to you and to Cigna. We commit to protecting your personal health information. We ensure our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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