Preventive Care Form

Please Note: This form is NOT a physician order.

Participant:
Please fill out and sign Section 1.
Healthcare Provider*: Please fill out and sign Section 2. * **For purposes of this form, "Healthcare Provider" includes a licensed health professional, for example: MD, DO, PA, or NP.**

Submit Form to:
Fax: (207) 561-3454
Mail: UMS Employee Benefits Center, University of Maine at Augusta-Bangor, 65 Texas Ave, Bangor, ME 04401
Email: benefits@maine.edu

IMPORTANT:
1. All information is required to process this form.
The form must be received by UMS no later than 11/30/22.

Section 1: Completed by Participant

Participant Name:	☐ **Employee** ☐ **Spouse/Partner**
UMS Employee Name (if different):	**Employee ID:**

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION· I hereby authorize the University of Maine System (UMS) to use my protected health information for the purposes of health and wellness programming. **Effective Period**: This Authorization shall be in full force and effect until the termination of my participation in my, or my spouse's, employer's health and wellness program or upon the termination of my, or my spouse's, employer's UMS administered health and wellness program, whichever is later, at which time this Authorization expires. **Information Subject to Use or Disclosure**: I understand that UMS may use and disclose any and all of the information obtained from the instant health screening pursuant to this Authorization. This information includes biometric data. **Purposes of Disclosure**: I understand that UMS may use the information subject to this Authorization for the purpose of administering my, or my spouse's, employer's health and wellness program. **Right to Revoke**: I understand that I have the right to revoke this Authorization by notifying UMS, in writing, at University of Maine System, Attn: Employee Benefits Center, 65 Texas Avenue, Bangor, ME 04401, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization. I understand that, in the event that I revoke this Authorization I may no longer be eligible to qualify for certain incentives that are contingent upon my participation in my, or my spouse's, employer's health and wellness program. **Conditional Authorization**: I understand that signing this Authorization is voluntary, however, my participation in my employer's health and wellness program may be conditioned on my signing this Authorization. *I understand that if I do not sign this authorization, I, or my spouse, may not be eligible to obtain certain incentives, if any, from my, or my spouse's, employer's health and wellness program.* By signing below, I acknowledge that **I HAVE READ CAREFULLY** and understand the above, and have had any questions explained to my satisfaction •

Signature:	**Date:**

Section 2: Completed by healthcare provider—*use "Preventive" or "Annual Wellness" billing codes.*

Preventive Screenings: Please only provide screening dates (mm/dd/yyyy) from April 1, 2021 through November 30, 2022 (and use "Preventive" or "Annual Wellness" billing codes when submitting claims.)

Annual Preventative Care:		Routine Ob/Gyn:	
Colonoscopy:		Cervical Cancer Screening:	
Prostate Exam:		Mammogram:	

Healthcare Provider's Name (Please Print or Use Office Stamp):		
Office Address:		Phone:
City:	State:	Zip:
Healthcare Provider's Signature:		Date:

Fax completed form to (207) 561-3454