

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
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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

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 <input type="text"/> <input type="text"/> . <input type="text"/>	Height/weight (required) Feet <input type="text"/> Inches <input type="text"/> Pounds <input type="text"/>	Waist circumference Inches <input type="text"/>	Blood pressure Systolic <input type="text"/> Diastolic <input type="text"/>	
Fasting blood sugar mg/dl <input type="text"/>	Non-fasting blood sugar mg/dl <input type="text"/>	Total cholesterol mg/dl <input type="text"/>	LDL cholesterol mg/dl <input type="text"/>	HDL cholesterol mg/dl <input type="text"/>

OR

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

City State Zip

Today's Date MM DD YYYY

Signature of Health Care Professional/Doctor (required)

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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