IT'S BETTER AT Fred Beans FAMILY OF DEALERSHIPS

# Fred Beans Annual Wellness Screening Form

## Section 1: Patient Information and Attestation (to be completed only by patient)

| | | | |
|---|---|---|---|
| Patient Name (Last, First) | | Employee Name (if different than Patient Name) | |
| Date of Birth | Phone Number | Email Address (if available) | Medical Member ID |
| Street Address | | | |
| City | State | Zip Code | Date of Appointment |

I certify that the information I provided above is complete and accurate. I attest that I have received the services as noted below per my practicing physician.

Patient Signature _____ Date _____

**Do not submit this form without your physician's signature below.** Completed forms must uploaded in the benefits portal. Please take this form to your annual wellness visit and your doctor will complete it. Then use the "Life Change Event" option on your benefits portal. Choose – Life Change Event – put in the date completed – and then choose "Wellness Credit – Medical" as the Life Event code, next upload the completed form and click submit (you will need to enter your password to confirm). HR will then receive the request and approve to begin your credit. (You will see the credit listed on your pay statements under the BIO pay code in the earnings section) If you need assistance, please contact HR@fredbeans.com.

*Please remember a newly completed Annual Wellness Screening form will be needed during the next Open Enrollment period which is held every June.

## Section 2: Service Information and Provider Attestation (to be completed only by physician)

Please confirm that the patient above has received the following services at their annual wellness examination. **DO NOT** send any results, simply check the below boxes for each item ordered and completed:

- ☐ Annual Physical Examination
- ☐ Height and Waist Measurements
- ☐ Lipid Panel and Blood Glucose Reading
- ☐ Blood Pressure Reading

I certify that the information I provided above is complete and accurate. I attest that the patient listed above has received the services indicated.

Physician Signature (or office stamp) _____ Date _____

Name *(printed)* _____ Phone Number _____