Annual Physical Exam Form

This year as a qualifying activity for the health and well-being program, you can complete an age-appropriate annual physical between **April 1, 2023 and March 31, 2024** with your personal healthcare provider.

Take this form to your appointment with your provider to be signed. **Please return the signed form to Twila Sikkink. This must be done by *March 31, 2024.*** Forms after this date will not be accepted.

To be completed by participant:

Patient Name: (please print) _____

Patient date of birth:
(DD/MM/YYYY) _____

Gender: _____

Patient phone number: (with area code) _____

Patient email: (optional) _____

Signature: _____

By signing this you are authorizing your healthcare provider to give this information to HealthPartners for health plan administration purposes. You are also authorizing HealthPartners to release program completion information to the employer sponsoring the plan or their designated business associate in order to administer the reward program. This authorization expires once the information is disclosed. Please note: You may incur costs such as co-pay and/or deductible for conditions discussed with a healthcare provider. Please speak to your clinic regarding their billing practices.

Important Information: You may revoke this authorization any time by writing to HealthPartners, WHPWB Customer Service, Mail Stop 21111H, Minneapolis, MN 55440-1309; but this will not affect information that has already been disclosed. You are not required to sign this authorization to be eligible for plan coverage or benefits; however, if you do not authorize this disclosure of information, you will not be eligible for any incentive discount. Information disclosed may no longer be protected by federal privacy laws. You can have a copy of this signed form.

Health care provider instructions

This form helps employees and spouses enrolled in their employer medical plan earn a preferred benefit incentive.

To be filled out by your healthcare provider

Date of visit: (DD/MM/YYYY) _____

Provider name: (please print) _____ **Provider Title:** (please print) _____

Provider signature: _____ **Phone:** _____

HealthPartners®