Physician Engagement Directions

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|[ ]  To find a Primary Care Physician (PCP) go to [HealthPartners](https://www.healthpartners.com/fcp/csearch/?networkId=1042&asOfDate=2023-06-07&group=hp&type=doctor&distance=20&hDistance=20&empId=null) or call 952.883.5000 |
|[ ]  Schedule your annual physical exam* SEH health coverage pays for one annual physical/preventive exam per year.
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|[ ]  Complete annual physical exam between **November 1, 2023 - October 31, 2024** |
|[ ]  You and your PCP must complete and sign the PHYSICIAN FORM included on page 2. |
|[ ]  Employee to submit completed form(s) by 11/15/2024 in ADP  |

Once all required action steps are completed, participants will save on their bi-weekly premiums beginning **1/1/2025**.

* **Both the employee and spouse/domestic partner** on the medical plan must participate to receive the wellness credit**.**
* **Employee** is responsible for submitting the form(s) into ADP
* **New Enrollment Requirements:** If you are enrolled in the medical plan 1/1/2024-07/31/2024 you must complete the Physician Engagement Program to earn the wellness credit. If you were enrolled in the medical plan after 07/31/2024, you will automatically receive the wellness credit for 2025.
* **Privacy** - SEH will NOT have access to any specific, personally identifiable health information. SEH takes your privacy seriously and complies with all requirements of state and federal privacy laws.

 Physician Engagement Form

*Part 1: To be completed by the* ***employee or spouse patient******before*** *providing the form to the Physician.*

**Tobacco Attestation.** Check One:

[ ]  I am NOT a tobacco user. I understand if I use tobacco products or start using tobacco products, I forfeit any remaining wellness credit effective as of the month following the disclosure.

[ ]  I am a tobacco user, and willing to participate in a “Tobacco Cessation” program through Healthpartners.

[ ]  I am a tobacco user, however I decline to participate in a cessation program. *Note: Participation in the tobacco cessation program may occur at any time.*

My signature acknowledges all information checked and noted and authorizes my Physician/Physician’s office personnel to provide the information in part 2 to SEH.

Patient Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

*Please check the applicable box:* [ ]  *Employee* [ ] *Spouse/domestic partner*

If Spouse/domestic partner, please provide employee name: Click or tap here to enter text.

Signature Date Click or tap to enter a date.

*Part 2: To be completed by* ***Physician***

SEH (employer) is sponsoring a voluntary Physician Engagement wellness program for the health of its employees. This program is intended to foster the patient and physician relationship.

***Please perform the following preventive tests and measurements if necessary:***

* Full cholesterol panel, glucose (or A1c) and triglycerides
* Blood pressure
* Height, weight, and waist circumference
* Other preventive tests as deemed appropriate*.*

(Patient Name) completed their annual physical on (date)

 Health Care Provider Name, Address and Phone Number:

Physician/Health Care Provider Signature: