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Description automatically generatedPhysician 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. |
|  | 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.

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Description automatically generated 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: