VERIFICATION FORM FOR THE 2024 USW/CLEVELAND-CLIFFS HEALTH AWARENESS INITIATIVE

INSTRUCTIONS:

-Separate forms are required for each employee/retiree and spouse, if applicable.
-Employees/retirees or spouses: Fill out Section 1
-Healthcare provider: Fill out Section 2
-Successful completion of the 2024 Health Awareness Initiative by you and your spouse, if applicable, qualifies you for HRA funding in 2025.

IN ORDER TO MEET THE 2024 HEALTH AWARENESS INITIATIVE REQUIREMENT:

(1) It is mandatory that the employee/retiree and spouse, if applicable, each submit this completed form, and
(2) The Wellness Examination must be completed between **10/01/2023 - 09/30/2024**, and
(3) This completed form must be submitted by 11/15/2024.

SUBMIT FORMS BY EMAIL OR MAIL:

Email: **ccliffshai@gmail.com** (you will receive an email confirmation once your form has been received and reviewed)
Mail: Steelworkers Health and Welfare Fund, 60 Blvd of the Allies, Suite 700 - Pittsburgh, PA 15222

SECTION 1

Patient Information: ***(TO BE COMPLETED BY EMPLOYEE, RETIREE OR SPOUSE - PLEASE FILL OUT ALL ITEMS IN THIS SECTION)***

Check One: ☐ ***I AM AN ACTIVE EMPLOYEE, RETIREE, OR SURVIVING SPOUSE***
☐ ***I AM THE SPOUSE OF AN EMPLOYEE OR RETIREE AND AM COVERED UNDER THEIR CLEVELAND-CLIFFS HEALTHCARE PLAN***

Last Name:	First Name:	MI:

Home Address:	City:	State:	Zip:

Email Address:

Date of Birth:	Phone:	Status of Employee: ☐ **Active Employee** ☐ **Non-Medicare Retiree or Surviving Spouse**

Insurance Card ID# *(NUMERIC PORTION ONLY)*:

SIGNATURE: ***DATE:***

SECTION 2

Healthcare Provider: ***(TO BE COMPLETED BY PROVIDER - DO NOT PROVIDE EXAMINATION RESULTS)***

The above named patient was seen in my office on the date of service listed below. I completed the examinations of height, weight, blood pressure, and a discussion of appropriate recommended exams, screenings and procedures. ***Provider is not liable if patient does not follow recommendations.***

Date of Service:	

Provider Name:	Provider Phone:

PROVIDER SIGNATURE: ***DATE:***

***ATTENTION PROVIDER:**
Work physicals: A Work Physical does not qualify as a wellness exam.
Preventive testing: When ordering preventive testing for your patient, please refer to the Highmark BCBS Preventative Schedule for covered testing when tests are ordered and coded as preventive/screening. Tests not included within this schedule will not be covered without a diagnosis code other than "routine", and patient could be responsible for the entire charge. Tests ordered and coded for diagnostic purposes will be processed under the diagnostic benefit, and medical policy guidelines will be used in determining benefit and payment.

Form revised 9/5/2023

Patient Registration Form - USW ANNUAL WELLNESS VISIT

HealthPoint Wellness

Patient Information

Patient Information: (PLEASE FILL OUT ALL SECTIONS BELOW)

Last Name:	First Name:	MI:	Sex: ❑ Male ❑ Female

Mailing Address: City: State: Zip:

Home Phone:	Cell Phone:	Work Phone:

Social Security #:	Date of Birth:	Do you have a Primary Physician?: ☐ Yes ☐ No *If yes, list name:*

Email Address:

Marital Status:	Personnel Status:	If you are the spouse of an employee, Do you have other medical insurance?
☐ Married ☐ Divorced ☐ Legally Seperated ☐ Single ☐ Widowed ☐ Partner	☐ Active Employee ☐ Spouse of Employee ☐ Retired	☐Yes ☐ No *If "YES", Please provide primary insurance information to us.*

If you are the spouse, list the Employee Name AND Employee Date of Birth:

Patient Consent

Patient Consent, Acknowledgment, and Authorization

INSURANCE AUTHORIZATION/ASSIGNMENT RELEASE:
I request that payment of authorized medical benefits be made to HealthPoint Wellness LLC for any services provided to me. This assignment of benefits includes Medicare, state medical assisted agency programs, commercial insurance, managed care plans, and any third party payer benefits that I may have. I authorize the use of this signature on all my insurance claim submissions.

I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information required to determine these benefits for related services.

I authorize a copy of this authorization to be used in place of the original.

FINANCIAL RESPONSIBILITY:
I am responsible for all the financial obligations of health services, and for the reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance. I also understand that if a payment becomes more than 90 days past due, I will be responsible for the balance due on my account as well as any and all reasonable attorney fees and costs of collections in the event of default.

VISIT CONSENT/RELEASE:
I understand that this wellness visit is designed to determine preventive health recommendations only, and is not an examination to detect and/or treat any health issues or diseases. I further understand, it is my responsibility, and at my own discretion, whether to follow-up on any health recommendations that were provided by HealthPoint Wellness LLC and I hereby release HealthPoint Wellness LLC, as well as their staff, from any, and all liability, which may arise from my failure to seek necessary healthcare, regular or otherwise.

COMMUNICATION CONSENT:
I allow HealthPoint Wellness LLC to contact me in the future by phone, text, email, and/or mail. I understand that e-mail and/or text is not a confidential means of communication. I agree to waive any rights that I may have against HealthPoint Wellness LLC, any affiliated organization, or provider for any loss of information due to technical failures and/or unintended breach of confidentiality, due to unauthorized access to my information, as a result of my decision to communicate with HealthPoint Wellness, LLC in this manner.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have received the Notice of Privacy Practices from HealthPoint Wellness LLC.

CONCIERGE CONSENT & AUTHORIZATION:
I authorize HealthPoint Wellness and its providers to disclose necessary protected health information to affiliated institutions in order to provide health concierge/navigator services or accommodate other applicable healthcare orders. This includes, but is not limited to, demographics, visit notes, medical records, wellness guidelines, and health history. Additionally, by signing this form, I allow the Health and Wellness Concierge/Navigator or affiliated personnel to contact me in the future by phone, text, email, and/or mail regarding my wellness visit recommendations.

By signing below, I acknowledge I have read, understand, and agree to the disclosures on this form. I further certify all information I provide is true and correct to the best of my knowledge.

Signature of Patient : **X** _____ **Date:** _____