wellness corporate solutions

BOYD GAMING

Instrucciones de Formulario de Certificado de Doctores

Si no participa en las evaluaciones de salud en el lugar programadas por la Compañía y desea visitar a su médico en otro momento para obtener sus números biométricos, también debe completar el Formulario de datos adjunto y enviarlo por fax/recibido a más tardar el 31 de Marzo de 2020

Siga estas instrucciones para asegurarse de que sus números biométricos se registren de manera adecuada y oportuna:

1. Verifique la sección de Información del participante del formulario de datos adjunto, y fírmelo y feche.

2. Entregue o envíe el Formulario de datos a su médico, y pídale que llene la sección mediciones corporales y Resultados biométricos del formulario, y que lo firme y feche. Nota: los resultados deben ser de una visita a su médico después del **1 de Enero de 2020**.

3. No se pueden enviar por fax otros formularios, informes de laboratorio u otros documentos adjuntos que no sean el formulario de datos adjunto aquí. Todos los formularios de datos deben enviarse por fax por separado, uno a la vez.

4. Informe al médico que el formulario de datos completo debe enviarse por fax lo antes posible, pero a más tardar el 31 de Marzo de 2020, al número de fax que figura a continuación. NOTA: El formulario de datos debe ser enviado por fax directamente por su medico, no por el miembro del equipo:

   Wellness Corporate Solutions
   Attn: Information Management

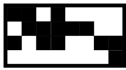
   FAX SEGURO: 1-888-893-6729

5. O puede cargar su formulario electrónicamente en el portal de detección siguiendo este enlace: http://boyd.wellemployeesolutions.com. El formulario debe estar en formato PDF y tener menos de 1 MB.

6. Es responsabilidad del miembro del equipo asegurarse de que el consultorio de su médico haya enviado por fax el formulario de datos hasta el 31 de Marzo de 2020. Si desea verificar el recibo del formulario de Wellness Corporate Solutions (WCS), puede llamar al 10 días hábiles después de que su médico haya enviado su formulario por fax, al 877-469-5411, de lunes a viernes, de 9 am a 5 pm, hora del este. Tenga en cuenta que no habrá extensiones al plazo del 31 de Marzo de 2020.

7. Si usted o su cónyuge desean recibir una confirmación por correo electrónico del recibo de su formulario de datos, debe imprimir claramente su dirección de correo electrónico en el campo de correo electrónico del formulario del PCP. Si se hace esto, debería recibir la confirmación por correo electrónico de WCS 10 días hábiles después de que su proveedor haya enviado su formulario por fax.

Si tiene alguna pregunta sobre el Formulario de datos, comuníquese con el Servicio al cliente de Wellness Corporate Solutions al 877-469-5411, de Lunes a Viernes, de 9 am a 5 pm, hora del este.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DATA FORM FOR BODY MEASUREMENTS & BIOMETRIC RESULTS WITH YOUR PERSONAL PHYSICIAN

PARTICIPANT: Complete participant information, send form to provider for completion and faxing.
PROVIDER: Complete Body Measurements & Biometric Results, sign and fax the form to Wellness Corporate Solutions at **1-888-893-6729** by **March 31, 2020**

BOYD GAMING

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT) PLEASE PRINT CLEARLY

FIRST NAME (same name as on your Anthem ID card) | LAST NAME (same name as on your Anthem ID card)

DATE OF BIRTH (MM/DD/YYYY) __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

BOYD GAMING TEAM MEMBER ID# **(REQUIRED)**

PHONE NUMBER ___ - ___ - ____

GENDER: ○ Male ○ Female RELATIONSHIP: ○ Team member ○ Spouse

EMAIL ADDRESS

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks, and that participation in the health screening and any affiliated wellness program is voluntary, meaning it is not required. I understand that my employer or plan sponsor cannot deny me access to health coverage or have the extent of my benefits limited, or subject me to any adverse employment action or retaliation for not participating. I confirm that prior to participating I have been presented and had the chance to review the EEOC Notice for Employer-Sponsored Wellness Programs specific to this program. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me, except under legal exceptions allowed for administration of this program. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information, but which does not identify me. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs or for industry research. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. By signing below I am providing prior, knowing, voluntary consent to participate in the health screening and any affiliated wellness program and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT SIGNATURE (REQUIRED) ____________ DATE ________

BODY MEASUREMENTS & BIOMETRIC RESULTS (TO BE COMPLETED & FAXED BY PHYSICIAN, NOT TEAM MEMBER)

DATE COLLECTED __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

FASTING STATUS: ○ Yes ○ No

*Note: Collection/office visit date must be after **January 1, 2020***

BODY COMPOSITION & BLOOD PRESSURE		BLOOD TEST RESULTS	
HEIGHT (without shoes)	__ **feet** __ __ . __ **inches**	TOTAL CHOLESTEROL	mg/dL
WEIGHT (without shoes)	__ __ __ . __ Pounds	HDL CHOLESTEROL	mg/dL
BMI	__ __ . __ kg/m ^{2}	LDL CHOLESTEROL	mg/dL
WAIST	__ __ . __ Inches	TRIGLYCERIDES	mg/dL
BLOOD PRESSURE	__ __ __ / __ __ __ mmHg	GLUCOSE	mg/dL
NOTES:			

ALL DATA MUST BE PROVIDED ABOVE USING PRE-DEFINED FIELDS. <u>LAB REPORTS, OTHER FORMS OR ANY TYPE OF ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED.</u>

PHYSICIAN SIGNATURE (REQUIRED)

__ __ / __ __ / __ __ __ __
SIGNATURE DATE (MM/DD/YYYY)

PHYSICIAN NAME (PRINTED)

___ - ___ - ____
PHONE NUMBER (PROVIDER/CLINIC)

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX:1-888-893-6729