Caregiver Wellness

Must be completed by a licensed health professional (M.D., D.O., NP, PA) and emailed directly to employeewellness@integrisok.com

Provider Information (Please Print)

Last Name: _____ First Name: _____ M.I.: _____
Office Address: _____ City: _____ ZIP: _____
Office Phone: _____

Patient Information
Last Name: _____ First Name: _____ M.I.: _____
Employee ID: _____ Date of Birth: _____

To be completed by the Provider

Biometric Data **(Required)**

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____/ _____

Pulse: _____

Preventive Care (Please provide dates)

Date of labs completed, including lipid panel, HbA1c, and BMP? _____ **(Required)**

Date of last mammogram? _____

Date of last PAP smear? _____

Have you ever completed a colorectal screening? For example, colonoscopy, fecal blood occult test. If so, date _____

I authorize my patient to join the applicable Lifestyle Management and/or Care Coordination program, including physical activity to help maintain or improve their health status.

Provider Signature: _____ Date: _____
*Any additional tests or issues addressed during the exam will incur additional charges.

Physician Office Use Only – It is important that this exam is coded correctly to ensure proper reimbursement.

- Primary Diagnosis Routine Physical Z00.00
- Well Visit and Physical – use CPT Code 99381-99397
- Modifier IH must be added

If you have any questions or issues with billing for this process, WebTPA will be happy to help.
Please email completed form or program questions to employeewellness@integrisok.com.
Deadline: October 31, 2023