2016-2017 HSE Annual Physical Form

This form is to be completed and submitted by the medical provider's office when an HSE health plan participant completes his or her annual physical.

Note to HSE Plan Participant:
To meet program requirements annual physicals must be completed between Aug. 1, 2016 and July 31, 2017.

Note to Providers: Please complete this form and fax the top portion to **317.594.4817.** The bottom portion should be detached and given to the participant for his or her records.

Participant information

Name (last, first, middle initial): _____

Employee ☐ or spouse of: _____

Date of birth (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Date of physical exam (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Section below to be completed by physician or healthcare provider:

I confirm that the individual named above visited my office on the date listed above for a physical exam/lab results that included the following tests: Blood pressure, BMI, total cholesterol and A1C or fasting glucose. *(Healthcare provider please do not send exam results.)*

Provider signature: _____ Date: _____

Note: Provider should also complete the bottom portion of form for the participant's records.

Provider's office: Cut along dotted line and give bottom portion to participant. Please fax top portion to **317.594.4817.**

Participant's copy

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I confirm that_____visited my office for a physical exam that included the following tests: Blood pressure, BMI, total cholesterol and A1C or fasting glucose.

Provider signature:_____ Date: _____

Participant should keep this copy in personal records as verification that annual physical was completed.

Please contact Nancy McCool at nmccool@hse.k12.in.us if you have any questions or want to verify receipt of this form.