UNIVERSITY OF NEBRASKA AT OMAHA

HEALTH AND WELLNESS FAIR

Wellness Blood Screen Instructions
Thursday, November 3, 2016
Registration starts Wednesday, October 12, 2016

FORMS

Three forms in addition to this instruction sheet should have printed out for you to complete.

1. 2016 Wellness Blood Screen Registration Form
2. Consent and Release for the 2016 Wellness Blood Screen
3. Health Insurance Claim Form –*make a photo copy of the front and back of your insurance card*

HOW TO SUBMIT

You can submit this to Health Services by the following ways:

1. Fax it to Health Services at 402-554-2387
2. Mail it through campus mail to Health Services 102 HPER
3. Bring completed papers to Health Services to register in person
4. Email it to jkalasek@unomaha.edu

PAYMENT

Payment forms include any **one** of the following:

- If you want Health Services to file with your insurance company then complete the Health Insurance Claim form. We are unable to submit claims to Medicare or Medicaid. Health Services has 6 in-network providers that we can submit claims to. They are:
  - Aetna
  - Blue Cross Blue Shield
  - Cigna
  - Coventry
  - Midlands Choice
  - United Health Care
  - TriCare
- If you are self-paying, you can pay with cash, credit card, check, payroll deduction, or MavCARD in person in Health Services, 102 HPER.
- If you are faxing or mailing your registration and want to pay with a credit card, you must call Health Services with your credit card number at 402.554.2374.
- If you are sending your registration in the mail and want to pay with a check, make it out to UNO Health Services.

MAKING YOUR APPOINTMENT

- Register in person in Health Services in 102 HPER.
- If you mailed or faxed your registration, you will need to call Health Services to get an appointment time.
- We must have your registration and form of payment (filing with insurance, check, credit card, cash, payroll deduction or Mav Card) in hand to schedule your appointment time.

If you have any questions, please call Health Services at 402-554-2374. Fax number is 402-554-2387.

REMBEMBER TO FAST FOR 12 HOURS PRIOR TO YOUR BLOOD DRAW TIME

TIME: _____

2016 Wellness Blood Screen Registration

Please Print Remember to fast for 12 hours

Name: Last First Middle Initial	Date of Birth __ / __ / ___ (mo.) (day) (yr.)	NU ID# or last 4 digits of your SSN# __ __ __ __ __ __ __ __
Address: _____ City: _____ State: _____ Zip: Telephone: (_____) __ __ __ - __ __ __ __	☐ Male ☐ Female **Status:** ☐ Student ☐ Faculty ☐ Staff ☐ Retiree ☐ Alumni ☐ Other	

I am requesting the following option(s) for my Wellness Blood Screen:

☐ **Option 1: Health Screen** ☐ **Self-pay: $40** ☐ **Insurance: $50**
Tests included: thyroid, cholesterol, HDL, LDL, triglycerides and glucose.
Also, tests that detect cell disorders and chemical imbalances for the kidneys and liver.

☐ **Option 2: Health Screen + PSA** ☐ **Self-pay: $55** ☐ **Insurance: $70**
Tests included: all of the above and the Prostate Specific Antigen (PSA) test.
Test for men ages 50 and older, or 45 with a family history.

☐ **Option 3: Hemoglobin A1C** ☐ **Self-pay: $20** ☐ **Insurance: $25**
Screening test for diabetes

☐ **Option 4: Vitamin D** ☐ **Self-pay: $35** ☐ **Insurance: $40**
Vitamin D plays an important role in prevention of bone disease, muscle strength, cancer prevention, cardiovascular risk, etc.

☐ **Option 5: HS-CRP** ☐ **Self-pay $35** ☐ **Insurance: $40**
Recognizing that atherosclerosis (plaques lining the surface of our coronary arteries) involves a chronic inflammatory process has brought greater attention to arterial "inflammation" as a risk factor for heart attack and stroke. HS-CRP is an inflammatory marker.

If you have questions regarding your Wellness Blood Screen lab results please call Health Services at 402-554-3171 to speak to a nurse.

Total for Cash-Check-Credit Card

Option 1: $_____
Option 2: $_____
Option 3: $_____
Option 4: $_____
Option 5: $_____
Total $_____

FOR OFFICE USE ONLY

Date:
_____

Total to Submit to Insurance

Option 1: $_____
Option 2: $_____
Option 3: $_____
Option 4: $_____
Option 5: $_____
Total $_____

Payment Type: ☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Payroll Deduction** ☐ **Mav Card**

Insurance Company Name
_____

Consent and Release for the 2016 WELLNESS BLOOD SCREEN

I authorize consent to Physician's Laboratory personnel to obtain a venous blood sample for voluntary lab testing. The possible risks associated with the blood collection procedure may include but are not limited to: inflammation, bruising, hematoma formation, and/or nerve damage. I acknowledge the risks and volunteer freely to the above procedure. Physician's Laboratory Services assumes no responsibility for complications.

I authorize release of results by the testing laboratory to UNO Health Services, for data analysis and to **myself only and do not hold the testing laboratory responsible to notify my physician of abnormal results.**

As an active participant in my health, I _____ (print name) will notify my primary health care provider of abnormal results or questions about my results as soon as possible. All test explanation materials enclosed with my lab levels are informational only and do not replace the consultation of my primary health care provider.

I, for myself, my heirs, my family, my executors, administrators, and assignees, do hereby waive and release the Board of Regents of the University of Nebraska, the University of Nebraska Omaha, their employees and agents, for all claims of negligence, damage, demands, actions, or other claims in any manner arising or growing out of my participation in the health screenings/tests.

I have read and understood the above paragraphs and agree to sign this Consent and Release Statement.

_____ _____

(Signature) **(Date)**

University of Nebraska Omaha

Wellness Blood Screen

Health Insurance Claim Form

University of Nebraska – Omaha, Health Services, 102 HPER
6001 Dodge St Omaha NE 68182

Directions:

Complete sections 1-6

1. Name: Last First Middle Initial	**2. Date of Birth:** __ / __ / ___ (mo.) (day) (yr.) **Sex**: ☐ Male ☐ Female
3. Address: _____ City: _____ State: _____ Zip: _____ Telephone: (_____) __ __ __ - __ __ __ __	**4. Patient Relationship to Insured:** ☐ Self ☐ Spouse* ☐ Child* ☐ Other* ***If you are the spouse, child or other of the insured card owner, complete the red box below**

5. Insurance Company Name:	**Insurance ID Number:**	**Group/Plan Number:**
Insurance Company Address:	**Insurance Company Phone Number:**	

Diagnosis Code: **Z00.00**

6. Patient's Authorizing Signature: I authorize the release of any medical or other information necessary to process this claim.

Signature_____

Date _____

Complete this box with the card owners name if you are the spouse, child or other of the card owner

Insured's Name (Last , First, MI)	
Insured's Address	
City	
Zip	Telephone ( )
Insured's date of birth ____ / ____ / _____ (mo.) (day) (yr.)	Insured's Sex ☐ Male ☐ Female
Employer's Name	Insurance Plan Name or Program:

Date of Service	**Procedure(s) CPT**	**Charges**
1.		
2.		
3.		
4.		
Total Charges:	Amount Paid:	Balance Due:

Revised 10/11/16