

# WELLNESS SCREENING FORM

Instructions for patients and health care professionals

- ▶ Print a copy of this form and bring it with you to the doctor's office.
- ▶ Fill out the Patient Information section. Answer every question. Form cannot be processed if incomplete.
- ▶ Your doctor, or other health care professional, should fill out the Wellness Screening Information section.
- ▶ Please be sure to write clearly, sign and date the form. Forms without a signature and date are incomplete.
- ▶ If you have any questions, call us using the phone number on the back of your Cigna ID card.

## Marking instructions

A	B	C	D	E	1	2	3	4	5
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Shade like this → ●  
Not like this → ⊗ ⊙

## Forms may be sent by:

**MAIL:** Cigna Customer Service  
PO Box 5201-5201  
Scranton, PA 18505

**FAX:** 1.877.916.5406  
Enter on the fax cover sheet:  
"CONFIDENTIAL"

**ONLINE:** Electronically upload your form at [myCigna.com](http://myCigna.com)

## PATIENT INFORMATION

Relationship: Subscriber  Spouse/domestic partner  Dependent  Gender: Male  Female

Patient's First Name  MI  Patient's Last Name

Street Address, Apt Number, PO Box

City  State  Zip

Patient Date of Birth  
MM  DD  YYYY   
Preferred Telephone Number       Is this a home  or cell  number?

Social Security (SSN) Last 4 numbers     *Note: Please use the last 4 digits of patient's SSN*  
Patient's Cigna ID Number on ID card        
Cigna Group Account Number on ID card

Customer Signature (required). My signature means that the information on this form is correct.  Today's Date MM  DD  YYYY

I understand that Cigna receives this information, and may use for determining my eligibility for incentives when applicable.

## WELLNESS SCREENING INFORMATION

Date MM  DD  YYYY

<b>BMI</b> <input type="text"/> <input type="text"/> . <input type="text"/>	<b>Height/weight (required)</b> Feet <input type="text"/> Inches <input type="text"/> Pounds <input type="text"/>	<b>Waist circumference</b> Inches <input type="text"/>	<b>Blood pressure</b> Systolic <input type="text"/> Diastolic <input type="text"/>	
<b>Fasting blood sugar</b> mg/dl <input type="text"/>	<b>Non-fasting blood sugar</b> mg/dl <input type="text"/> <b>OR</b> <input type="text"/>	<b>Total cholesterol</b> mg/dl <input type="text"/>	<b>LDL cholesterol</b> mg/dl <input type="text"/>	<b>HDL cholesterol</b> mg/dl <input type="text"/>

Health Care Professional/Doctor First Name  MI  Health Care Professional/Doctor Last Name

City  State  Zip

Today's Date MM  DD  YYYY

Signature of Health Care Professional/Doctor (required)

Your Privacy is important: The privacy of your health information is important to you and to Cigna. We commit to protecting your personal health information. We ensure our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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