ARBenefitsWell – Primary Care Provider (PCP) Form

ARBenefits ASE / PSE Member Instructions

Members who complete a wellness screening through their own physician must have this form completed for the visit to count towards the ARBenefits wellness program requirements. **If you complete a worksite checkup through Catapult Health, you do not need to have this form completed.**

This form must be completed and returned by the deadline stated at the bottom of the page. It is the responsibility of the member, not the physician, to make sure this form is completed and submitted by the program deadline. Guidelines for the ARBenefits Wellness Program can be accessed in the Wellness section at www.transform.ar.gov/employee-benefits. Please contact the Department of Transformation and Shared Services: Employee Benefit Division for further questions through phone at 877-815-1017 x1 or email at askebd@dfa.arkansas.gov.

PLEASE PRINT CLEARLY.
If your information is not easily readable, it will not be recorded.

PATIENT AUTHORIZATION AND RELEASE

I agree to the release of the information requested below from my provider to ARBenefits to complete requirements for the ARBenefits*Well* program. **ALL INFORMATION REQUESTED BELOW IS REQUIRED.**

PATIENT'S FIRST AND LAST NAME (PRINTED): _____

AR BENEFITS MEMBER ID #: _____ **DATE OF BIRTH:** _____ /_____ /_____

PATIENT'S SIGNATURE: _____ **E-MAIL:** _____

SOCIAL SECURITY # (LAST 4 DIGITS ONLY): _____ **MOBILE #:** (_____) _____ - _____

PROVIDER INSTRUCTIONS

To meet the wellness program requirements, your patient must complete a preventive checkup which includes all screenings listed below (or be exempt due to pregnancy). If the patient is an admitted nicotine user, a cotinine (nicotine) screening is not required. **PLEASE COMPLETE ALL INFORMATION, THEN RETURN THIS FORM TO YOUR PATIENT.**

☐ ***Please check this box if your patient is pregnant and exempt from completing lab work.***

PROVIDER'S NAME (PRINTED): _____ **PROVIDER'S SIGNATURE:** _____

Date of Tests	/ /		**Did patient fast?**	☐ YES ☐ NO
Height	feet inches		**Weight**	lbs.
Abdominal Circumference	inches		**Blood Pressure**	/ mmHG
Total Cholesterol	mg/dL		**HDL Cholesterol**	mg/dL
LDL Cholesterol	mg/dL		**Triglycerides**	mg/dL
Glucose	mg/dL		**Admitted nicotine user**	☐ YES ☐ NO
			Cotinine (nicotine)	☐ POSITIVE ☐ NEGATIVE

This completed form must be received by October 31, 2020
Send via fax to: 1-833-323-4329
Send via e-mail to: health.services@dfa.arkansas.gov