



2403 Sidney Street, Suite 220B
Pittsburgh, PA 15203
1-800-451-6889

Dear Participant,

Integrated Corporate Health (ICH) is proud to partner with The City of Pittsburgh to facilitate programs for your health screening needs. This year The City of Pittsburgh is offering the opportunity for employees who are unable to participate at an onsite screening to obtain their results directly from their primary care physicians. Any co-pay, deductible, or cost for form completion will be the employee's responsibility. The fingerstick screening includes the following:

- Total cholesterol
- Blood sugar
- Blood pressure

You will need to contact your health care provider so that you can complete the screening. If you have obtained all of the required results anytime since **January 1, 2015**, then your provider may use that to complete the Screening Results form.

In order to satisfy this component of your wellness program your screening results must be sent to Integrated Corporate Health between the following dates:

- **Beginning: September 1, 2015**
- **Ending: October 31, 2015**

It is critical that your information is returned to Integrated Corporate Health in a timely manner. Your results MUST BE returned by your physician by direct mail or fax. Once you have had your screening with your doctor, please notify Charisse Smith in the Benefits Office at (412) 255-2950 to ensure that we have record of your screening along with your physician name and phone number.

See the attached instruction sheet that is included in this letter for detailed instructions.

If you have further questions regarding The CityFit Wellness Program, please contact the Wellness Office. If you have questions regarding the screening process or results, please contact Integrated Corporate Health at 1-800-451-6889.



Participant Instructions

Included in this packet is a **Screening Results** form to take to your Health Care Provider.

Step 1: Contact your primary care physician to make a preventive visit appointment and to obtain your biometric results and fasting lipid panel test. To ensure accurate results, we recommend that you fast 9 to 12 hours prior to your testing; however, water and black decaffeinated coffee/tea are acceptable. You are encouraged to take medication as prescribed by your physician. Please note any copays, deductibles or cost of form preparation by your health care provider is your responsibility.

Step 2: Provide your health care provider with the **screening form (see attached form)**. Your signed form must be completed and include:

- Blood Panels – with a copy of the actual lab report
- Blood pressure reading (systolic/diastolic)

Step 3: Ensure you have signed the Screening Results Form. Both you and your provider must sign the form. Forms without both signatures will NOT be accepted.

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Physician Instructions

Step 1: Complete and sign the **Screening Results** form.

Step 2: Include a **copy of the actual lab results**.

Step 3: Return the Screening Results Form and Lab Copy to ICH Data Management by fax or mail to:

Integrated Corporate Health
2403 Sidney Street, Suite 220 B
Pittsburgh, PA 15203
or
Fax: 412-432-5714

If you have any questions, please contact ICH at 1-800-451-6889 or ichoffice@icorporatehealth.com



THE CITY OF PITTSBURGH PDR SCREENING RESULTS FORM

TO BE COMPLETED BY PARTICIPANT:

Participant Name	
Member ID as it appears on insurance card	
Home Address: Street City, State zip	
Date of Birth (mm/dd/yyyy)	____/____/____
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Phone Number	(____) ____ - _____
Email	

I authorize my health care provider to release my results to Integrated Corporate Health (ICH). I understand that per ICH's Notice of Privacy Practices, available at www.icorphealth.com, by calling ICH at 800-451-6889 or through my HR department, my health information may be disclosed by ICH to provide payment, for health care operations or if required by law to third parties. This disclosure could be to my insurer/administrator/health plan. I also understand that it is my responsibility to 1) direct questions regarding testing to those administering the tests and 2) follow up with my physician to discuss the results of these tests.

PARTICIPANT SIGNATURE _____ TODAY'S DATE ____/____/____

Critical Dates:

<p>Lab results may be from the period: <u>January 1, 2015</u></p> <p>Lab results Due to ICH: <u>October 31, 2015</u></p>
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COMPLETED BY MEDICAL PROVIDER ONLY

	Value	Date of Test
Total cholesterol (mg/dL)*		
Glucose (mg/dL)*		
Blood pressure:	_____	
If over 140/90 , repeat once	_____	
If over 160/100 , repeat twice	_____	
Fasting 9-12 Hours	Y	N

Please also include a **copy of the actual lab results. By signing below I certify results are correct.*

Facility Name _____ Facility Phone Required _____
 Printed Name of Medical Provider _____ NPI Number _____
 MEDICAL PROVIDER SIGNATURE _____ *Today's Date ____/____/____

**If date is not supplied, received fax date or posted date on mailed envelope will be used as the screening date.*

Please fax completed form and results to ICH at 412-432-5714 by **10-31-2015. Date faxed ____/____/____ Or mail to Integrated Corporate Health, 2403 Sidney Street, Suite 220B, Pittsburgh, PA 15203.**