KAISER PERMANENTE® thrive

PREVENTIVE HEALTH SERVICES CONFIRMATION

This form is intended to provide employers proof that a Kaiser Permanente member has completed certain preventive health services to qualify for a wellness incentive program.

Member's Personal Contact Information (not employer's)
Full Name: Street Address: City, State, Zip: Phone:

Kaiser Permanente Preventive Health Services Clinical Guidelines Confirmation	
	Date Tested / notes
Blood Pressure: ages 18+, within 2 years	
Body Mass Index (BMI): ages 18+, within 2 years	
Glucose: ages 18+, within 5 years	
Total Cholesterol: ages 18+, within 5 years	
Other (write-in):	

Kaiser Permanente Confirmation

The above Kaiser Permanente member has completed the recommended preventive health services outlined above, or it has been determined that one or all are not needed at this time based on the member's specific circumstances.

Name _____ Title _____

Signature _____ Date _____

NOTE TO KAISER PERMANENETE PROVIDER

Due to privacy regulations, Kaiser Permanente may <u>NOT</u> send this form directly to employers, their administrators, or their vendors. This form may only be provided directly to the member.

Employee / Member Instructions for Returning Form to Employer

(*Kaiser Permanente may <u>NOT</u> send this form on behalf of employees. Employees must send the form themselves.*)