For Your Health Program Instructions

Three simple activities, three opportunities to earn rewards!

VISIT YOUR PROVIDER
A frank, yearly discussion with your health care provider to create an individualized care plan is an important step in staying healthy.

COMPLETE A HEALTH SURVEY
We’d like to get to know you better. Completing our short health survey helps us make tailored suggestions on how to keep you healthy.

OBTAIN LAB TESTS
Assessing your health starts with basic lab tests. Have your provider order lab tests and discuss the results with them.

$75 reward + $75 reward + $100 reward = $250 in rewards!

Four easy steps to earn and redeem your rewards!

1. Choose an activity, in any order you wish. Each activity is color-coded, and consists of an activity form plus a reward request form.

2. Mail the completed, color-coded activity and reward forms to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190

3. We’ll process your forms. Keep in mind your reward will arrive from our rewards vendor, NGC - National Gift Card.

4. Repeat this process for all three activities to earn $250 in rewards!

Questions? Contact For Your Health at 1-888-280-8737 (TTY: 711), 9 a.m. to 5 p.m. Monday - Friday or at wellness@lassohealthcare.com

For Your Health incentive program subject to change. Reward requests processed within 5 business days after receipt. Please allow up to 21 business days to receive a physical card via mail. Lasso Healthcare is an MSA plan with a Medicare contract. Enrollment in the Plan depends on a contract renewal.
Thank you in advance for completing Lasso Healthcare's health survey. It should take between 10 and 15 minutes to complete. Please return your completed survey, along with your completed health survey reward request form, to Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

IMPORTANT: PLEASE TAKE EXTRA CARE TO PRINT LEGIBLY IN INK AND BE SURE THAT YOU COMPLETELY FILL IN THE CIRCLES.

YOUR IDENTITY BASICS  Please confirm some basic information about yourself.

Member First Name ________________________________  Member Last Name ________________________________

Member ID # ________________________________  DOB _______ /_______ /________

Sex  ○ Male  ○ Female  ○ Intersex  Height ___ ft _____ in  Weight _________ lbs

Name of Primary Medical Provider

Name(s) of Specialist(s)

YOUR HOSPITALIZATION HISTORY

Have you been to the emergency room within the last year?  ○ Yes  ○ No

If Yes, when?  ______ / ______ / ______

If Yes, for what? ○ Accident (e.g., car accident, fall, etc.)  ○ Pain not caused by accident  ○ Illness

Have you been admitted to the hospital overnight, within the last year, for any medical or surgical condition or an accident?  ○ Yes  ○ No

If Yes, for what?

YOUR MEDICATIONS AND SUPPLEMENTS

Are you currently taking any prescription medications?  ○ Yes  ○ No  If so, how many? ______

Are you taking any non-prescription medications or supplements?  ○ Yes  ○ No  If so, how many? ______
YOUR CHRONIC CONDITIONS  Help us better understand any chronic conditions you may have.

DIABETES

Have you ever been diagnosed with/currently have Diabetes?  ○ Yes  ○ No  (if “No”, skip to next section)

Were you diagnosed with Type 1 or Type 2?  ○ Type 1  ○ Type 2  ○ Don’t know

Have you had complications?
   ○ Yes  ○ No

   If Yes, please describe the complications: _____________________________

Do you self-manage (e.g., glucose tests, exercise, diet, etc.)?  ○ Yes  ○ No

Do you see your medical provider regularly?  ○ Yes  ○ No

Did you have a lab test during the past year that tested your A1C levels?  ○ Yes  ○ No

Have you had an eye exam during the past year?  ○ Yes  ○ No

Have you had a kidney function test during the past year?  ○ Yes  ○ No

HIGH BLOOD PRESSURE

Have you ever been diagnosed with, or do you currently have, high blood pressure?  ○ Yes  ○ No  (if “No”, skip to next section)

Did you receive treatment or medication for your blood pressure during the last calendar year?  ○ Yes  ○ No

What was your blood pressure when last checked by your provider? If you don’t remember, what was it the last time you checked?  _________ / _________

HEART

Have you been diagnosed with a heart condition, such as: Irregular Heartbeat (i.e., atrial fibrillation or AFIB), Angina (e.g., chest pain with exercise), Heart Attack or Heart Failure (HF)?  ○ Yes  ○ No  (if “No”, skip to next section)

Are you under the care of a provider for any of these conditions?  ○ Yes  ○ No
### YOUR CHRONIC CONDITIONS, CONTINUED ...

#### LUNG

Have you ever been diagnosed with, or do you currently have, a chronic lung condition (respiratory) such as Chronic Obstructive Pulmonary Disease (COPD)?
- [ ] Yes
- [ ] No (if “No”, skip to next section)

Have you had any serious lung conditions, such as pneumonia or asthma?
- [ ] Yes
- [ ] No

Are you under the care of a medical provider for any of these conditions?
- [ ] Yes
- [ ] No

#### KIDNEYS

Have you ever been diagnosed with, or do you currently have, a serious kidney condition, such as kidney failure (nephropathy) or other condition?
- [ ] Yes
- [ ] No (if “No”, skip to next section)

Are you on dialysis?
- [ ] Yes
- [ ] No

#### LIVER

Have you ever been diagnosed with, or do you currently have a liver problem, such as hepatitis or cirrhosis?
- [ ] Yes
- [ ] No (if “No”, skip to next section)

Have you had or been tested for Hepatitis C?
- [ ] Yes
- [ ] No

Are you under the care of a medical provider for any of these conditions?
- [ ] Yes
- [ ] No

#### CANCER

Have you ever been diagnosed with, or do you currently have, cancer?
- [ ] Yes
- [ ] No (if “No”, skip to next section)

What type of cancer were you diagnosed with?

Are you currently being treated?
- [ ] Yes
- [ ] No

#### GI/IMMUNOLOGIC/RHEUMATOLOGIC/MUSCULOSKELETAL

Have you ever been diagnosed with, or do you currently have, rheumatoid arthritis, immunologic Lupus or other arthritic conditions?
- [ ] Yes
- [ ] No (if “No”, skip to next section)

Were you issued one or more prescriptions for an anti-rheumatic or immunologic drug?
- [ ] Yes
- [ ] No
YOUR CHRONIC CONDITIONS, CONTINUED ...

MENTAL HEALTH

Have you ever been diagnosed with:

- Bipolar disorder
- Schizophrenia
- Depression
- Other

If so, are you under the care of a medical provider for the condition(s)?

- Yes
- No

If so, are you on medication?

- Yes
- No

LIFESTYLE PROFILE  Help us build a profile of your personal lifestyle habits that may impact your health.

Do you smoke?

- Yes
- No (if “No”, skip to next question)

If Yes, what product(s) do you use?

- Cigarettes
- Cigars
- Vape/e-cigarettes

If Yes, are you interested in quitting?

- Yes
- No

How many alcoholic beverages do you consume, on average, per week? (A typical drink is 12 oz. of regular beer, 5 oz. of wine or 1.5 oz. of distilled spirits; e.g., gin, rum, tequila, vodka, whiskey, etc.)

- 0
- 1 - 3
- 4 - 7
- > 7

Have you taken any opioid or narcotics, prescribed or unprescribed, in the last year?

- Yes
- No

If Yes, who prescribed the opioid/narcotic?

- PCP/Specialist
- Urgent Care/ER
- Unprescribed

If Yes, are you taking it regularly for chronic pain?

- Yes
- No

PREVENTIVE ACTIVITIES  Describe the key things you do to help maintain your health.

Do you exercise?

- Yes
- No

In the past year, have you discussed exercise with your medical provider and did he/she advise you to start, increase, or maintain your physical activity during the year?

- Yes
- No

Do you have an annual routine physical or wellness visit with your medical provider?

- Always
- Most Years
- Sometimes
- Rarely
- Never

Women: Have you discussed breast cancer screening and/or mammograms with your medical provider?

- Yes
- No
- Not Applicable

If applicable, how many years ago did you have your last mammogram?

______ Years ago
PREVENTIVE ACTIVITIES, CONTINUED ...

Men: Have you discussed prostate cancer screening with your medical provider?

☐ Yes  ☐ No  ☐ Not Applicable

If applicable, how many years ago did you have your last prostate screening?

______ Years ago

Have you ever had a colonoscopy?

☐ Yes  ☐ No

Have you discussed how often you should receive regular colonoscopies with your medical provider?

☐ Yes  ☐ No

When was the last time you had a bone density screening (i.e., a bone mass measurement)?

______ Years ago

Have you had a problem falling, walking or balancing over the past year?

☐ Yes  ☐ No

Have you discussed fall prevention with your medical provider?

☐ Yes  ☐ No
Congratulations on completing the health survey activity!

Please fill out this form and return with your completed health survey to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

First name: ___________________ Last name: ___________________
Member ID: ___________________ Phone number: ___________________

STEP 1: Select one $75 reward. Place an X next to the $75 reward you wish to receive. Choose either:

A) Brand reward
- □ Amazon.com
- □ Barnes & Noble Gift Card
- □ Cracker Barrel

B) Visa® Prepaid Card
- □ Visa

Please note Visa Reward cards are only distributed via mail as physical cards; a Visa reward cannot be requested/received via email.

The physical Visa Reward card can be used for both online and in-store purchases.

STEP 2: Select your delivery. Place an X next to the email or mail option below.

- □ E-code via Email address*
- □ Physical Card via Mailing address:

*You agree to receive email from Lasso Healthcare/For Your Health.

Lasso Healthcare is an MSA plan with a Medicare contract. Enrollment in the Plan depends on contract renewal. The For Your Health program incentives, reward brands and amounts are subject to change. Reward requests will be processed within 5 business days after receipt. Please allow up to 21 business days to receive a physical card via mail. Rewards cannot be replaced if lost or stolen. Rewards non-redeemable for cash. See reverse for important information.
Complete Section 1 of this form, then ask either your medical provider (e.g., your physician) or labs provider (e.g., the lab manager, lab technician, phlebotomist, etc.) to complete and sign Section 2. Please return this form along with your completed labs reward request form to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

IMPORTANT: Please print clearly in ink.

Section 1: To be completed by you ...

Member First Name ___________________________ Member Last Name ___________________________

Member ID # ___________________________

Provider Name ___________________________

Section 2: To be completed by your provider ...

The purpose of the patient presenting this form to you is to help them follow the USPSTF preventive care guidelines and to qualify them for a member health incentive from Lasso Healthcare.

Date of Service _______ / _______ / _______

Were the prescribed labs completed per provider’s orders? ☐ Yes ☐ No

Provider Signature ___________________________________________ Date ___________________________

Credentials ___________________________________________ NPI ___________________________
Congratulations on completing the labs activity!

Please fill out this form and return with your completed labs activity certification form to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

First name: ___________________ Last name: ___________________

Member ID: ___________________ Phone number: ___________________

STEP 1: Select one $75 reward. Place an X next to the $75 reward you wish to receive. Choose either:

A) Brand reward

1. Amazon.com Gift Card
2. Barnes & Noble Gift Card
3. Cracker Barrel Gift Card

B) Visa® Prepaid Card

4. CVS Pharmacy Gift Card
5. GiftCards.com
6. JCPenney

STEP 2: Select your delivery. Place an X next to the email or mail option below.

☐ E-code via Email address:

☐ Physical Card via Mailing address:

*You agree to receive email from Lasso Healthcare/For Your Health.

Fastest delivery!

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Complete Section 1 of this form, then ask your provider to complete and sign Section 2. Please return this form along with your completed annual wellness visit reward request form to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

IMPORTANT: Please print clearly in ink.

Section 1: To be completed by you ...

Member First Name ___________________________ Member Last Name ___________________________

Member ID # ___________________________

Provider Name ___________________________

Section 2: To be completed by your provider ...

The purpose of the patient presenting this form to you is to help them follow the USPSTF preventive care guidelines and to qualify them for a member health incentive from Lasso Healthcare. Today’s visit, in addition to labs recommended by you to this patient, should form the basis of a personal care plan for the patient to follow in accordance with the USPSTF. If the patient has completed lab work within the last 3 months, or the most recent labs drawn are still considered clinically valid and reliable in your opinion, new labs do not have to be ordered/drawn.

Date of Service ___________ / ___________ / ___________

Type of Visit

- [ ] Welcome to Medicare Visit
- [ ] Medicare Annual Wellness Visit
- [ ] Routine Physical

Provider Signature ___________________________ Date ___________________________

Credentials ___________________________ NPI ___________________________
Congratulations on completing the annual wellness visit activity!

Please fill out this form and return with your completed annual wellness visit activity certification form to: Lasso Healthcare, Attn: For Your Health, 34 Executive Drive, Danbury, CT 06810-4190.

First name: ____________________  Last name: ____________________

Member ID: ____________________  Phone number: ____________________

STEP 1: Select one $100 reward. Place an X next to the $100 reward you wish to receive. Choose either:

A) Brand reward

- [ ] Amazon
- [ ] Barnes & Noble Gift Card
- [ ] Cracker Barrel

B) Visa® Prepaid Card

- [ ] Visa

Please note Visa Reward cards are only distributed via mail as physical cards; a Visa reward cannot be requested/received via email.
The physical Visa Reward card can be used for both online and in-store purchases.

STEP 2: Select your delivery. Place an X next to the email or mail option below.

- [ ] E-code via Email address*
- [ ] Physical Card via Mailing address

*You agree to receive email from Lasso Healthcare/For Your Health.

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