

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.

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Activity Form: Health Survey

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

If Yes, please describe your typical exercise regimen (type of activity or activities, duration/how long and frequency/how often).

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

Reward Request: Health Survey

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: _____

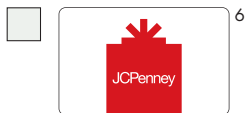
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STEP 1: Select one \$75 reward. Place an X next to the \$75 reward you wish to receive. Choose either:

A) Brand reward

— OR —

B) Visa® Prepaid Card



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.



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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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Activity Form: Labs

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 _____

Reward Request: Labs

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

— OR —

B) Visa® Prepaid Card



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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Activity Form: Annual Wellness Visit

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 _____

Reward Request: Annual Wellness Visit

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

— OR —

B) Visa® Prepaid Card



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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:



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