AFFILIATED PHYSICIANS AND EMPLOYERS HEALTH PLAN
2018 WELLNESS PROGRAM HEALTH ACTIONS FORM

Upon Completion, Submit this form to:
Fax: 833-639-2329
Mailing address:
Affiliated Physicians & Employers Health Plan
P.O. Box 5487
Somerset, NJ 08875
Attn: Operations Coordinator

Requirement*	Physician/Facility Signature	Date Completed
Only complete for those actions where you meet the criteria.		
▪ Biometric Screenings		
o Blood Pressure	_____	_____
o Body Mass Index (BMI) Screening	_____	_____
o Cholesterol & Glucose Screening	_____	_____
▪ Health Actions		
o Preventive Office Visit (Annual Physical Exam)	_____	_____
o Colorectal Screening[1]	_____	_____
o Mammography Screening[2]	_____	_____
▪ Health Risk Assessment Questionnaire	Signature Not Required	_____

Member ID#:_____

* Reimbursement is not paid per activity. Member must complete all requirements that meet their age criteria or have their physician indicate reason for non-compliance to be eligible for reimbursement. All information provided on this form may be verified by the Plan through claims data or by calling your physician's office.

[1] *All individuals over age 50 should have colorectal screening performed once every 5 years. If you have previously met this requirement or your physician opts you out, you can have your physician sign the form indicating the reason.*
[2] *All women age 40 and older should have a mammography screening performed once per year*