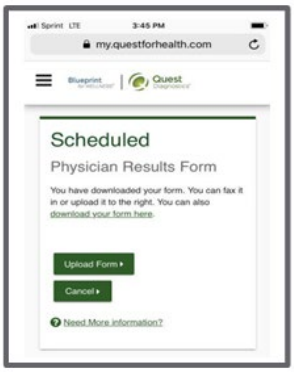
How to submit your Physician Results Form

Complete

- To complete your biometric screening, provide the enclosed Physician Results Form to your doctor
- Your doctor must complete the Health Provider section, including **Signature**, **Date Test(s) Performed,** and **UPIN/ NPI** (your doctor will know this number)
- Laboratory results must be collected between 02/01/2024 and 12/16/2024 to be accepted
- Review the Quest Diagnostics Terms and Conditions page; by signing the Physician Form you are acknowledging and agreeing to the Quest Diagnostics Terms and Conditions

Upload

- Visit **My.QuestForHealth.com** and log in with the username and password you created previously.
- Take a clear picture of your results form
- Select **Upload Form**
- Locate and select the Physician Results Form file (jpg, .png, .gif, and .pdf file formats will be accepted)
- If you are uploading the form from a mobile device, you will need to select an image of the form from your stored photos



Verify

- This form is unique to you and will be rejected if submitted containing anyone else's information
- Enter your results from the form into the fields shown before clicking the **Submit** button
- You will receive a "results are ready email" within 10 business days; if not please make sure the form was submitted correctly.

Alternative option: You or your physician can fax the form to 1.844.560.5221.

Ensure your form is accepted by following these steps:

- Date Test(s) Performed - Have your doctor collect your lab results between 02/01/2024 and 12/16/2024 . *Results collected before or after this date will not be accepted.*
- Use black ink and write legibly.
- All required form fields must be completed. You and your doctor need to sign the form.
- Confirm your form was successfully uploaded or faxed to Quest Diagnostics. You are responsible for ensuring you or your physician returns this form by 12/16/2024 . *Results received after this date will not be accepted.*
- If you have already completed your annual preventive care visit, your doctor's office may charge a copay and/or a form completion fee. You are responsible for paying co-pays and/or fees.

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Quest Diagnostics™

Physician Results Form

Completed form can be faxed to **844-560-5221**
Participant can also upload form to the Quest Wellness Screening Portal.

REQUIRED ALL FIELDS ARE REQUIRED unless otherwise noted with (*). Your form will be rejected if all fields are not completed. If you have not completed these tests with your Healthcare Provider, they will need to be completed before this form is submitted. Complete in BLACK INK for best results.

Company Name	FCSRMC	Contract Name	FCSRMC 2024

You need to fill this section out. ! Complete this section before you see your healthcare provider.

Last Name	Participant	First Name	Sample	MI	E

Self Identified Gender	☐ Female ☒ Male	UID	abc123456789

Email Address	sampleparticipant@xxxx.com	Phone Number	

Address	10101 Renner Blvd

City	Lenexa	State	KS	Zip Code	66219

By signing this requisition form and receiving these services, I acknowledge and agree to the Terms of Service which have been provided to me by Quest Diagnostics.

Participant Signature		Date of Birth	01/01/1999

FOR LAB USE ONLY	0000 0000 0000 0000

This section must be completed by your Healthcare Provider. ! The information provided below will be kept confidential.

Date Test(s) Performed	MM-DD-YY	Testing and Measurements Must be Collected Between	02/01/2024 12/16/2024

Height (feet)		Height (inches)		Weight (lbs)		Systolic BP		Diastolic BP	

Trigs (mg/dL)		HDL		Total Chol		LDL	

Glucose (mg/dL)		Fasting >9 Hours	☐ Yes ☐ No

Waist Circumference (inches)	*	

Healthcare Provider (Printed)		UPIN/ NPI	

Healthcare Provider (Signature)	

1. Terms of Service: Quest Diagnostics Employer Population Health ("EPH") supports health benefit management programs with policies in place to maintain the confidentiality of your information consistent with Quest Diagnostics Notice of Privacy Practices, which may be found at QuestDiagnostics.com/our-company/privacy. Our Privacy of Protected Health Information (PHI) policy requires that we must obtain, maintain, use, and disclose patient protected health information in a manner that protects patient privacy and complies with all state and federal laws. Though this is a voluntary program, should you choose not to accept these Terms of Service, you will not be able to participate.

2. You are participating in a voluntary population health program, and by your participation you freely and voluntarily assume any risks associated with the screening process. You must be 18 years of age or older. As needed for the program(s) available to you, you consent to the collection of a blood sample from a fingerstick or from the arm; measurement of blood pressure, height, weight, waist and/or hip measurements; the collection of a cheek swab or blood sample for the purpose of cotinine testing to detect tobacco use; the collection of a nasal swab for the purposes of performing a test for the detection of COVID-19 and/or to a blood draw to determine whether you have developed antibodies to COVID-19; and/or the collection of a fecal sample for Colorectal Cancer screening. You understand that collection of a blood sample involves certain potential risks that may include but are not limited to prolonged bleeding, fainting or feeling lightheaded, bruising and multiple sticks. If the program includes the reporting of results at the point of collection, this data should be considered preliminary, as the results are screening assessments only. The instrument used on-site may yield results that vary from what would be reported if the same testing was performed by the laboratory on a specimen obtained from your arm.

3. By participating in the population health program(s) you authorize and consent to Quest Diagnostics EPH's disclosure of the data and outcomes of your Health Questionnaire and test results in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and any other applicable laws. If you are providing family medical history or other genetic information through a Health Questionnaire or test results, you are also authorizing and consenting to the use of such genetic information for the purposes of the program as described in paragraph 4 below. If you are a spouse or dependent of another participant in the program, you are also authorizing and consenting to the use of your genetic information in your spouse's data. Genetic information may include, but is not limited to, blood pressure, BMI, and blood work results such as cholesterol, glucose, and triglycerides. Your employer will not receive your results in any form that may match the data to you; however, your employer's benefits plan, which may be self-administered, may receive identifiable information for purposes of managing the benefits plan or administering incentives on your behalf.

4. If your employer or program sponsor selects additional health benefits management services as part of this population health program then, at the direction of your employer or program sponsor, your data may be shared with healthcare professionals/companies and/or your employer's Group Health Plan representatives who offer additional services provided by your employer. Data sharing with authorized third parties will be performed via a secure data exchange process designed to keep your personal and protected health information secure. In no event will Quest Diagnostics sell, exchange, or otherwise disclose your data except as stated in these Terms of Service.

5. To ensure optimal participation in a population health program, your employer or plan sponsor has engaged Quest Diagnostics EPH to contact you regarding your voluntary participation in the program. You may receive communications via telephone, email, and/or cell phone text messaging that include reminders, confirmations and instructions to participate, using information that you have provided, or that your employer and/or plan sponsor has provided to Quest Diagnostics EPH via an eligibility file. Electronic messages such as SMS and email, are unencrypted and there is a risk that they may be intercepted or viewed by others that are nearby, share or access your device, or if your device is lost or stolen. Results are not delivered via text or email, however the message may contain "health information" such as the name of the test.

6. If information was provided through an eligibility file from your employer or plan sponsor, then as part of the registration process you will be asked to verify and/or update your personal information. You are responsible for the accuracy of your personal information and at any time, you can return to the My.QuestForHealth.com site, log in, and provide additional updates to your personal information. If you provided a cell phone number as a means to contact you, you acknowledge and consent that we may contact you by telephone, voicemail and/or text message with respect to Quest Diagnostics EPH at that number. You also consent that we may contact you at that phone number using an automatic dialing and/or announcing device that may play pre-recorded messages. You are not required to provide a cell phone number and participation in Quest Diagnostics EPH population health programs is not conditioned on providing a cell phone number. If you wish to be contacted at another number or by another means, please edit your profile information at My.QuestForHealth.com. By accepting these terms, you consent to receiving these contacts intended to provide helpful and timely guidance regarding these services.

7. Use of the information collected through participation in this program is limited to the purposes stated in this notice. The personal information collected or generated through participation in this program is retained for as long as is required by applicable state and federal laws. Upon the expiration of that retention period, it is disposed of in a secure manner compliant with the requirements of HIPAA.

8. The information you receive from participating in this program does not constitute the practice of medicine and is provided to you for informational purposes only. It is not meant to replace the customary physician-patient relationship. You are encouraged to share this information with your health care provider for medical treatment purposes, or for interpretation of the results in conjunction with your medical history, when appropriate.

9. I hereby release and discharge, to the extent permitted by law, Quest Diagnostics, my employer, my insurer/payer/third-party administrator and of each, the controlled and controlling entities and affiliates and each of their respective officers, directors, employees, agents and contractors, program sponsors and their related agents, from any and all claims or causes of action on account of any injury to me which may result from my participation in this population health program. This release shall be binding upon my heirs, assigns, executors, administrators and personal representatives.