Ingersoll Rand
Inspiring Progress™

Health Progress

Health Progress
Biometric Screening Health Care Provider Form
2016-2017 Program Year

This form is to be used only by salaried and non-union hourly employees, including Trane Sales employees, and by La Crosse, Lexington, Madison Heights, Rushville, Thermo King Minneapolis, Trenton, and Tyler union employees and eligible spouses

All employees and eligible spouses are encouraged to take an active role in managing their health by completing a biometric screening. You may use this form (if eligible) to submit your biometric screening results as completed by your health care provider to participate in the screening component of your incentive program. Please follow the instructions below to submit your results to Healthyroads.

INSTRUCTIONS:

1. Read the Use and Disclosure Statement at the bottom of page 1.
2. Complete Part 1 of the form. All fields marked with an asterisk are required.
3. To meet applicable reward requirements, your results must be current within the past 12 months. (The Medical Plan will pay for one physical in a 12-month period.)
   a. Health care provider sign off date must be between **10/01/2016** and **12/31/2016** in order for you to earn the Health Progress reward.
   b. All of the asterisked times in Part 2 of the form must be completed as part of your visit in order to earn the Health Progress reward
4. Give this form to your provider and ask them to complete Part 2 and sign the form after writing in your screening results.
   a. You may be responsible for any charges relating to the completion of this form or office visits as billed by your provider.
   b. Laboratory reports should not be submitted. Healthyroads will not review laboratory reports to obtain and process data values. Healthyroads will only process data entered on this form by your HCP.
5. Make and keep a completed copy of this form for your records.
6. Confirm your form is fully completed including signatures from both you and your physician
7. Send your completed form to Healthyroads by fax, email*, or mail. Forms must be received on or before **12/31/2016** to be eligible for your Health Progress reward. Information provided to Healthyroads will be treated in compliance with HIPAA Privacy and Security standards.
   - Fax Number: 1-844-257-7842
   - Email Address: IRProviderReportedForms@ashn.com
   - Mailing address: Health Progress – Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040

   *Security measures available through email services can vary; because of this Healthyroads encourages you to check with your email provider and/or organization about the security protections available to the emails you send before emailing your form to Healthyroads.
8. Your results will be viewable on www.myhealthprogress.com under My Health à Scorecard within 10 business days of receiving your completed form. Your incentives program will also be updated at that time. Once your form has been processed, an email will be sent to you letting you know that your Scorecard has been updated on myhealthprogress.com. (You must provide a valid email address to receive this notification) **If your form is incomplete, it will not be processed.**
9. If you have questions about this form, your incentive program, or Healthyroads services please contact Healthyroads at 1-888-975-2746 or email Healthyroads at HealthProgress@healthyroads.com.

Healthyroads® Biometric Assessment Information Use and Disclosure Statement

Healthyroads, Inc. and its affiliates or subsidiaries as well as their successors, assignees, and licensees (hereinafter "Healthyroads") may use and/or provide the information relating to the biometric assessment tests to your plan sponsor or health plan, or to other entities that have contracted with your plan sponsor or health plan, as applicable, to administer your plan. In addition, Healthyroads may also use your personal information obtained through the biometric assessment results form to provide you with information about other health-related benefits available to you through your plan sponsor or health plan, as applicable. That data may also be used to populate your online tools and trackers on Healthyroads.com, which may be used by your Healthyroads Coach® in connection with the Healthyroads Coaching Program if that program is available to you and you choose to participate in it. Provision of the information noted above to your plan sponsor, health plan, or other entities, as applicable, and for health coach outreach to the phone number you provide that have contracted with your plan sponsor or health plan to administer your plan, is intended for purposes related to treatment, payment (billing, eligibility) or operational and administrative requirements. Such purposes will vary by entity, but may include, eligibility for incentives due to participation in the program, quality control and auditing purposes, and facilitation with case management or disease management programs available from your plan sponsor or health plan, as applicable. In these situations, Healthyroads requires recipients of the information to ensure that there are safeguards in place so that personal information is only used for the purposes noted. If information is disclosed to plan sponsors who are employers, then such information is required to be used for benefit administration purposes only.

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Please print legibly using black or blue ink *only*. Incomplete or illegible forms will not be processed. Write your first and last name exactly the way that they appear on your payroll stub and/or your medical benefits card. PLEASE NOTE: Values below with an asterisk (*) are *required*. This form will not be processed if any required values are missing.

PART 1 – TO BE COMPLETED BY PARTICIPANT — HRDIR0001

*First Name: | *Last Name:

Employee Number: | *Date of Birth (MM/DD/YYYY): / /

Phone Number: | Email:

May we use the email address we have on file or as provided on this form, to return your form to you if needed? ○ Yes ○ No

PARTICIPANT ATTESTATION/AUTHORIZATION: I authorize my information (completed by my provider in Part 2 of this form) to be disclosed to and used by Healthyroads to help administer my employer-sponsored wellness program. I authorize Healthyroads to contact my provider to validate the information on this form, if necessary as determined by Healthyroads. I confirm I have read and agree to the Use and Disclosure Statement on page 1 of this form.

*Participant Signature: | Date: / /

PART 2 – TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient's employer is encouraging all of its participants to take an active role in managing their health by completing a biometric screening. In order for this form to be accepted it must contain biometric results within the past 12 months. The health care provider sign off date must be between **10/01/2016** and **12/31/2016**. Please provide all of the results below marked with an asterisk, sign, date, and return this form to your patient.

*Fasting? ○ Yes ○ No

Waist Circumference: in

*Weight: lbs

*Height: in

Please round to the nearest whole number

*Blood Pressure: / mmHG

*Total Cholesterol (mg/dL):

*LDL (mg/dL):

*HDL (mg/dL):

*Triglycerides (mg/dL):

*Blood Glucose (mg/dL):

Health Care Provider Name: _____ NPI#:

*Health Care Provider Signature: | *Date: / /

FORMS MUST BE RECEIVED BY: 12/31/2016

Fax: **1-844-257-7842** Email: **IRProviderReportedForms@ashn.com**

Mail: Health Progress – Attn: BIO DATA C4-1, PO Box 509040, San Diego, CA 92150-9040

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