

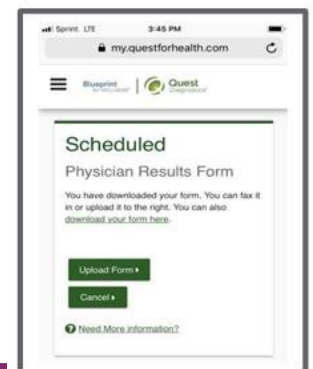
How to submit your Physician Results Form

Complete

- To complete your biometric screening, provide the enclosed Physician Results Form to your doctor. You may have out-of-pocket expenses associated with health screenings performed by your care provider if additional tests are requested. Confirm any out-of-pocket costs in advance by reviewing your medical plan details.
- Your doctor must complete the Health Provider section, including **Signature** and **Date Test(s) Performed**.
- Laboratory results must be collected and submitted **on the Quest website by Dec. 31, 2022** to be accepted. Be sure to leave enough time prior to deadline.
- 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

- Return to the Quest scheduling website where you downloaded your form
- 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



Alternative option: You or your physician can fax the form to 1.844.560.5220

Verify

- Once the form is uploaded, you will need to input your results.
- Make sure you submit your information. The form will be rejected if it is submitted containing anyone else's information.
- Enter your results from the form into the fields shown before clicking the **Submit** button.
- Once your physician results form has been uploaded successfully, you will receive a confirmation screen that states "Your Physician Results Form has been uploaded".
- You will receive a "results are ready email" within 10 business days; if not please make sure the form was submitted correctly by contacting Quest Diagnostics.

You can contact Quest Diagnostics for support at 844.350.4779 to check on the status of your form.

Ensure your form is accepted by following these steps:

- Date Test(s) Performed - Have your doctor collect your lab results no later than **Dec. 31, 2022**. *Results collected and submitted after this date will not be accepted.*
- Use black ink and write legibly.
- All required form fields must be completed. You and your doctor both 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 **Dec. 31, 2022**. *Results received after this date will not be accepted.*

Quest Diagnostics Incorporated and its subsidiaries (Quest) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.844.698.1022. ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.698.1022. 注意：如果您使用繁體中文 (Chinese)，您可以免費獲得語言援助服務。請致電 1.844.698.1022.

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Physician Results Form

Completed form must be faxed to **844-560-5220**.
Complete and submit by 12/31/2022

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	UNITEDHEALTH GROUP INC	Contract Name	UNITEDHEALTH GROUP INC 2022
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You need to fill this section out.

! Complete this section before you see your healthcare provider.

Last Name	SHANAM	First Name	RAJESH	MI	
Self Identified Gender	<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	B20DB6C6-2865-4A0C-9E76-81F64B85B144			
Email Address	SHANAMRAJESH91@GMAIL.COM			Phone Number	2039939647
Address	11254 PROVIDENCE LANE				
City	EDEN PRAIRIE	State	MN	Zip Code	55344

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	04/25/1991
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FOR LAB USE ONLY

E295 9613 2543 3560

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	07/01/2021	12/31/2022					
Height (feet)		Height (inches)		Weight (lbs)		Systolic BP		Diastolic BP	
Trigs (mg/dL)	*	HDL	*	Total Chol	*	LDL			
Glucose (mg/dL)		Fasting >9 Hours	<input type="checkbox"/> Yes <input type="checkbox"/> No						

Healthcare Provider (Printed)		UPIN/ NPI	
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Healthcare Provider (Signature)	
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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/home/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.