Group#19901

MedBen Employee Plan
Wellness Screening Confirmation Form

Patient Name: _____

Patient SSN: _____*DOB:* _____

*Physician Name:*_____*Office Phone:*_____

I certify the following screenings were performed on the dates listed:

Last Date *Screening*

___/___/___ *Annual Wellness Examination (Yearly beginning at 18)*

___/___/___ *Cholesterol Lipid Profile (Every 5 years beginning at 20)*

___/___/___ *Females – pap smear (Every 3 years beginning at 21; Every 5 years 30-64)*

___/___/___ *Females – mammography (Every 2 years beginning at 40)*

Males & Females 50 & over:

___/___/___ *Colonoscopy (Every 10 years beginning at 50)*

_____ _____
Signature of Physician *Date*

Please fax completed form to:
MedBen
Attn: WellLiving
Fax No.: (740) 522-7489
admin@medben.com

Mail Log Code "IH"