



**City of Independence WellLiving
Wellness Screening Confirmation Form**

Group#: 10487

Patient Name: _____ DOB: _____

Policy Holders ID Number: _____

Physician Name: _____ Office Phone: _____

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

Last Date Screening

___/___/___ Annual Wellness Examination (Male & Female age 18 and older)

___/___/___ Lipid Profile or total and HDL
Cholesterol (Male & Female age 20 and older)

___/___/___ Females – pap smear & pelvic exam (Age 21 and older)

___/___/___ Females – mammography (Age 40 and older)

___/___/___ Colonoscopy (Male & Female age 50 and older)

Signature of Physician

Date

Please fax completed form to:
MedBen
Attn: WellLiving
Fax No.: (740) 522-7483