



Dear Participant & Healthcare Provider:

NECA Local No. 145 IBEW Welfare Plan offers its eligible members & spouses a wellness incentive, and the requirement is to complete a biometric screening for the 2026 wellness program year for your 2027 incentive. Screenings completed between **January 1, 2026 - October 31, 2026** will be accepted.

Please note: **Both** the *physician* and the *eligible member or spouse* must sign the completed form to be accepted.

If you have any questions regarding NECA Local No. 145 IBEW Health Screening requirements, please contact Anna Vander Beek at avanderbeek@telligen.com.

Providers Please Note:

If the information is not available and you need to perform any testing to provide the below information, please code the visit as Preventive or Wellness so that patient is not charged a deductible or does not have to pay out of pocket for the visit.

Please submit the Heath Screening Results Form with lab results to Telligen **by November 1, 2026** via fax: **888-804-4595**

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.



Physician's Biometric Screening Results

PLEASE FAX TO TELLIGEN: 888-804-4595

PLAN NAME: NECA LOCAL NO. 145 IBEW WELFARE PLAN

PATIENT FULL NAME	MALE or FEMALE (CIRCLE ONE)	TEST DATE
PATIENT EMAIL	LAST FOUR DIGITS OF SSN	
DAY PHONE NUMBER	DATE OF BIRTH	

PLEASE INCLUDE THE FOLLOWING MEASUREMENTS/TESTS:

Full Lipid Panel (Cholesterol) Diabetes (Glucose) Blood Pressure Body Composition

Other _____

Fasting? YES _____ NO _____

Signature (Patient) _____ Date _____

BIOMETRIC SCREENING RESULTS:

TC: _____ HDL: _____ TRG: _____ LDL: _____ TC/HDL Cholesterol Ratio: _____ GLU: _____

Age: _____ Blood Pressure: _____ Weight: _____ Height: _____ BMI: _____ Waist: _____

Signature (Physician) _____ Date _____

Physician's Printed Name: _____

If the information is not available and you need to perform any testing to provide the below information, please code the visit as Preventive or Wellness so that patient is not charged a deductible or does not have to pay out of pocket for the visit.