



horizon Blue Cross Blue Shield of New Jersey

# State Health Benefits Program Retiree Wellness Program Annual Physician Certification

Please see next page for instructions on completing this form.

Please fax completed form to: 1-973-274-4485, Attention: SHBP RETIREE WELLNESS PROGRAM

Please Print

## Section A (To Be Completed by Retiree)

Horizon-BCBSNJ member ID Number:

Last Name:                      First Name:

Date of birth (MM/DD/YYYY):   /   /       Phone:    -    -

Date of Annual Physical (MM/DD/YY):   /   /

Member Signature\*: \_\_\_\_\_ Date:   /   /

## Section B (To Be Completed by Attending Physician)

Date of Annual Physical (MM/DD/YY):   /   /

List all health screenings completed during the year along with the date of completion. Use additional sheet of paper if necessary.

Health Screening/Date: \_\_\_\_\_ Date:   /   /

Health Screening/Date: \_\_\_\_\_ Date:   /   /

Health Screening/Date: \_\_\_\_\_ Date:   /   /

Health Screening/Date: \_\_\_\_\_ Date:   /   /

Physician's First Name:         Last Name:

Phone:    -    -

Physician Signature\*: \_\_\_\_\_ Date:   /   /

Tax ID or NPI#:

\*I certify that the information provided above is correct and authorize any provider who participated in care treatment to release all medical or other information requested by Horizon Blue Cross Blue Shield of New Jersey in conjunction with the Retiree Wellness Program. This information is for the sole use of the State of New Jersey and Horizon BCBSNJ to administer the Retiree Wellness Program. **Fraud warning:** Any person who knowingly files a statement containing false or misleading information is subject to criminal and civil penalties.

**We will advise the SHBP that you have completed the annual physical exam with health screenings requirement of the Retiree Wellness Program. Your individual results will not be reported to the SHBP.**

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# STATE HEALTH BENEFITS PROGRAM

## SHBP RETIREE WELLNESS PROGRAM ANNUAL PHYSICIAN CERTIFICATION FORM

(For Eligible Horizon-BCBSNJ SHBP Retiree Subscribers only)

### SUBMISSION INSTRUCTIONS

ONCE YOU ARE ENROLLED IN THE SHBP RETIREE WELLNESS PROGRAM,  
A FULLY COMPLETED COPY OF THIS FORM MUST BE RECEIVED BY DECEMBER 31<sup>ST</sup>  
EACH YEAR BY HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY TO  
MAINTAIN ENROLLMENT.

PLEASE DESTROY ANY PREVIOUS VERSIONS OF THIS FORM AND RETAIN A BLANK COPY OF  
THIS FORM FOR USE EACH YEAR. DO NOT SUBMIT ANY PREVIOUS VERSIONS OF THIS FORM.

Please fully complete Section A on the reverse side of this form and sign the form.  
Bring it with you to your annual physical examination.  
Have your physician fully complete Section B.

PHYSICIAN MUST INCLUDE TAX ID# OR NPI#, AND LIST THE DATE OF ANNUAL  
PHYSICAL, ANY OTHER WELLNESS EXAMS/SCREENINGS RENDERED & DATES  
SERVICES WERE RENDERED.

IF THE FORM IS MISSING ANY INFORMATION OR IS ILLEGIBLE, IT WILL NOT BE  
PROCESSED.

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*For speediest processing, please submit your Annual Physician Certification via FAX*  
to:

1-973-274-4485, Attention: SHBP RETIREE WELLNESS PROGRAM

**ALWAYS RETAIN A SUCCESSFUL FAX TRANSMISSION REPORT FOR YOUR  
RECORDS.**

Refer to your fax machine to insure you are transmitting the correct side of the  
document  
(Face-up versus face-down)

-OR-

MAIL the signed Annual Physician Certification to:

Horizon Blue Cross Blue Shield of New Jersey  
State Health Benefits Program – Retiree Wellness Program  
P. O. Box 820  
Newark, New Jersey 07101-0820

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NJ DIRECT and Horizon HMO cover one annual routine wellness physical  
examination per year. Completion of the Annual Physician Certification should be  
based on this examination.

Only one Annual Physician Certification must be submitted per calendar year.

**ALWAYS RETAIN A SIGNED COPY OF YOUR ANNUAL PHYSICIAN CERTIFICATION  
FOR YOUR RECORDS.**