



Office of Group Benefits Primary Care Provider Form 2026

Instructions for Active Employees and Retirees (OGB Louisiana Blue subscribers / policyholders)

If you were unable to receive a Ochsner Corporate Wellness screening this year, you can have your primary care provider report a completed checkup to receive credit toward the Office of Group Benefits wellness incentive. **Sending the completed form is ultimately your responsibility, not your provider's.**

Completed forms must be received by Ochsner Health by 5 p.m. on Sept. 30, 2026.

Please print clearly. All fields are required. Incomplete or illegible forms cannot be processed.

STEP ONE: PATIENT AUTHORIZATION AND RELEASE

With the understanding that my personal health information will only be shared as permitted and protected by law, I agree to the release of the information requested below from my Primary Care Provider to Ochsner Health in order to complete the requirements for my wellness incentive. Ochsner Health may disclose this medical information to me, to my health care provider(s), to my health plan, or a third-party entity designated by my current or any future health plan or employer for use in health and disease management programs. I understand this information may be used to identify my health risks, to provide education regarding how to address my identified risks, and to possibly contact me to promote participation in health and disease management programs.

PATIENT NAME* (FIRST, M.I., LAST) _____ GENDER* _____

DATE OF BIRTH* _____ LOUISIANA BLUE MEMBER ID* _____

PHONE NUMBER* _____ EMAIL ADDRESS* _____

MAILING ADDRESS* _____

PATIENT SIGNATURE* _____ DATE* _____

STEP TWO: PROVIDER INSTRUCTIONS

Office of Group Benefits has partnered with Ochsner Health to provide worksite wellness initiatives. Complete the information below and return this form to your patient or use the directions below to email, fax or mail to Ochsner Corporate Wellness.

PATIENT FASTING?* (CIRCLE ONE)				YES / NO	
HEIGHT*	FEET	INCHES	WEIGHT*	LBS.	
WAIST CIRCUMFERENCE*	INCHES		BLOOD PRESSURE*	/	
TOTAL CHOLESTEROL*	MG/DL		HDL CHOLESTEROL*	MG/DL	
LDL CHOLESTEROL*	MG/DL		TRIGLYCERIDES*	MG/DL	
GLUCOSE*	MG/DL		A1C* (as needed)	%	

PROVIDER NAME* (PRINT) _____ DATE* (March 1 – Sept. 30, 2026) _____

PROVIDER SIGNATURE* _____

STEP THREE: SUBMISSION INSTRUCTIONS

Completed forms must be sent to Ochsner Health for processing using one of the following secure methods. Forms must be submitted before 5 p.m. on Sept. 30, 2026. We recommend keeping a copy in case resubmission is needed.

Mail

Ochsner Corporate
Wellness
Attn: PCP Form Processing
400 Labarre Rd., 5th floor
New Orleans, LA 70121

Secure Fax: 504-353-
8830

Secure Email

1. Click the link below or copy and paste it into your browser to be taken to our secure email site:
<https://eftworkspaces.ochsner.org/messageportal/#/dropoff>
2. Enter your email address in the "From" field. Select Corporate Wellness in the "To" field.
3. Enter "OGB Form" in the Subject line.
4. Click Upload and select the form from your files.
5. Hit "Drop Files Off" to send.

Questions? Please email corporatewellness@ochsner.org.