CommunityCare™

Cardiovascular Screenings

Saint Francis Health System

1. Cardiac Calcium Screening - $99

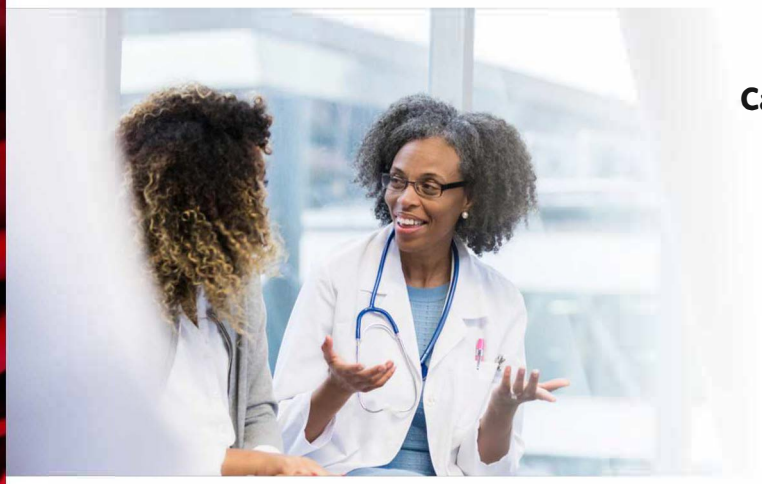
Measures the calcified plaque in the arteries that supply blood to the heart. This non-invasive CT scan takes about 15 minute and helps calculate your risk of a heart attack.

2. Set of Three Cardiovascular Screenings - $99

These quick and easy tests can help you identify potential risks for heart disease and other vascular conditions.

- **Carotid Disease** – This simple ultrasound helps detect plaque in arteries that can cause a stroke.
- **Abdominal Aortic Aneurysm** (AAA) – This test checks for enlargement of the part of abdominal aorta which suggests a risk for rupture.
- **Peripheral Arterial Disease** (PAD) – This condition of the arteries in the legs is related to an increased risk of heart attack or stroke. This test will record blood pressure in both legs to evaluate blood circulation.

Call 918-494-6900 to schedule your appointment



Ascension St. John

1. Cardiac Calcium Score - $99

Left untreated coronary plaque may cause blockages and heart attacks. A multislice CT scanner measures the calcified plaque in the arteries that supply blood to the heart, and indirectly measures the amount of plaque inside the heart by taking a series of pictures in just a few seconds.

2. Choose any three - $100

- **Carotid Artery Evaluation** - Plaque in the carotid arteries can reduce blood flow to the brain and may increase the risk of stroke.
- **Cardiac Function Evaluation** - An ultrasound probe is placed on your chest to evaluate heart function and calculate your ejection fraction, the amount of blood pumped out of the heart during each test
- **Ankle-Brachial Index** - Blood pressure is recorded from both ankles and arms to screen for peripheral vascular disease.
- **Abdominal Aorta Evaluation** – Abdominal aortic aneurysm is a localized enlargement of the abdominal aorta. An ultrasound is a highly specific, noninvasive test which measures the size of your abdominal aorta.

Call 918-744-3511 to schedule your appointment

Ascension St. John

SaintFrancis Health System

Upon completion of the screening test, please complete the claim form and email to csssupport@ccok.com, fax to **918-877-9750**, or submit via postal mail to the address on the claim form.

CommunityCare™

Send completed form and supporting documentation to:

CommunityCare
Williams Center Tower II
Two West Second Street, Suite 100
Tulsa, Oklahoma 74103

Claim Form - Member Reimbursement

Preparing Your Claim Form

- Complete all sections below. Include the original itemized purchase receipt for each over-the-counter item (copies will not be accepted.) If receipt does not give the description of the item, please include the actual packaging the item came in.
- Please keep copies for your files because claim information cannot be returned.
- Do not highlight the form or the enclosed information. Highlighting makes scanned and faxed documents difficult to read.
- As a participant, you have been assigned a unique Identification Number – 10 digits preceded with an alpha character. If you do not know your ID#, you can locate it through any of these sources: Explanation of Benefits (EOB), your CommunityCare ID card or by contacting Customer Service at (800) 777-4890.

1. Member Information

Member ID #	Last Name	First Name	MI	Daytime Phone #

Street Address	City	State	ZIP	Date of Birth

2. Contract Holder Information

Contract Holder's Name	Contract Holder's Employer	Group Number

3. Expense Information

Over-the-Counter Product Name/Description of Reimbursable Item. Written prescription for the over the counter item must be submitted when requesting reimbursement. *If the sales receipt does not give the description of the item you must submit the packaging with the UPC label to be considered a reimbursable item.*	Date of Purchase	Amount Submitted (including tax)
Cardiac Calcium - 76497		$
Three Cardiovascular Combo Screening - 76999		$
		$
		$
		$
		$
		$
	Total Submitted	**$**

4. Employee Certification

I certify that the expenses for which I am seeking reimbursement from the account have been incurred by me, or by an eligible member under my plan. Any person who knowingly, and with intent to defraud, files a statement of a claim containing any materially false, incomplete or misleading information is guilty of a crime.

Member Signature Date

Contract Holder *(if member is a minor)* Date

5. Patient's or Authorized Persons Signature for Release of Information

I authorize the release of any medical or other information necessary to process this claim.

Member Signature Date

Contract Holder *(if member is a minor)* Date