

Primary Care Provider - Biometric Screening & Review Incentive

PARTICIPANT INSTRUCTIONS:

When utilizing your Primary Care Provider for the [_____] incentive, this form must be completed to receive credit for your biometric screening and/or review appointment.
(year)

- Wellness Incentive steps must be completed between [_____] [_____].
(Incentive Date) (Incentive Date)
- To be eligible for the incentive, please fax this completed form and a copy of your lab results to the [_____] Health Center at [_____] by [_____].
(Client Name) (Fax Number) (Incentive Deadline)

Note: You will need to FAST (no food or beverage) for 8 hours prior to the biometric screening. It is recommended that you drink plenty of water before the blood draw. You may also have black coffee. Take any medication as prescribed.

Premise Health personnel will not be responsible for contacting an outside provider or patients to correct an incomplete or incorrect form. Please confirm all information is completed and correct before faxing.

If not already completed, please sign the *CONSENT-Incentive Program Employee Notice and Authorization* (attached) and return to the Health Center along with this form.

PROVIDER INSTRUCTIONS:

Your patient is participating in a voluntary incentive program. To earn the incentive, your patient must complete the following:

- Annual blood work to include the labs listed below
- Review of lab work results with a provider to discuss lab values and ways to work toward improvement of their overall wellbeing.

Please print clearly in CAPITAL LETTERS and fill out each blank space area using an ink pen (*required). Please complete the below attached form as noted, attach a copy of the lab results, and return to the patient for submission for their annual incentive program by [_____].
(Incentive Deadline)

The following benchmark values are for your reference. If the patient’s lab results are outside of the values listed, we recommend the patient be encouraged to work towards improvement for their overall wellbeing. Upon review with the patient, please complete the signature portion of the form.

Screening	Benchmark Values
Total Cholesterol <u>or</u> Total Cholesterol to HDL Ratio	Total Cholesterol \leq 220 <u>or</u> TC/HDL Ratio $<$ 5
Fasting Blood Sugar (Glucose) or Hemoglobin A1C	100MG/dL or less or HbA1c $<$ 5.7
BMI (Body Mass Index) <u>or</u> Waist Circumference	BMI \leq 30 Waist $<$ 40 inches (males) and $<$ 35 inches (females)
Blood Pressure	Systolic \leq 140
Blood Pressure	Diastolic \leq 90

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PATIENT INFORMATION:

*Patient's Last Name: _____ *Patient's First Name: _____
*Patient's Phone #: (____) _____ - _____ *Patient's DOB: ____/____/____
*Date of Visit: ____/____/____

REQUIRED VALUES:

*Height: _____ feet _____ inches *Weight: _____ pounds
*Blood Pressure: ____/____ *Waist Circumference (at navel level): ____ inches

***Blood Panel** – must include the following and a copy of blood work must be included with this form to be eligible for the incentive.

- Total Cholesterol
- LDL Cholesterol
- HDL Cholesterol
- T. Chol/HDL Ratio
- Triglycerides
- Glucose, Serum
- HbA1c (if glucose over 100 or known Diabetic)

As the Healthcare provider for the above-mentioned patient, I certify that they have received the required vitals and labs and I have reviewed the results with the patient.

PROVIDER INFORMATION:

Provider's Name: (print) _____
Provider's Signature: _____
Provider's Office Phone Number: _____
Provider's UPIN/NPI: _____