Biometrics Screening Results ð Health Care Provider Form

University of Alaska is providing the opportunity for eligible members to submit biometrics screening results from your Health Care Provider (HCP) to participate in the screening component of your incentive program. Please refer to the Instructions on the following page.

The date of your screening must occur on or after 7/1/2013 and this form must be completed and received by Healthyroads on or before 6/30/2014 to be eligible for the biometric screening component of your incentive program.

Please print neatly. Incomplete or illegible forms will not be processed and you will not receive incentive credit. Write your first and last name exactly the way that they appear on your payroll stub and/or your medical benefits card. PLEASE NOTE: Values below with an asterisk (*) are *required*. This form will not be processed if any required values are missing. Fax completed form to:
1-877-495-2746 by 6/30/2014

PART I ð To be completed by Eligible Member	
Employer Group: University of Alaska	Relation to Employee: ☐ Self ☐ Spouse/Domestic Partner
*First Name:	*Last Name:
Gender: ☐ Male ☐ Female	*Date of Birth (MM/DD/YYYY): / /
Phone Number:	Email Address:

MEMBER ATTESTATION/AUTHORIZATON: By submitting this form, I am authorizing my HCP to report my laboratory and biometric results to Healthyroads to be included as pa23..8 475.75 il om3l[Wlude8(77.55 Tm0 g[HC)).t3.64 3By submitting this form, I am authorizing m3ãFTŸ#Hv0H

			☐ Yes ☐ No	*Total Cholesterol (mg/dL):	
Pregnant?	☐ Yes ☐ No			*LDL (mg/dL):	
Waist Circumference (in):				*HDL (mg/dL):	
*Weight (pounds):				*Triglycerides (mg/dL):	
*Height:	ft in			Total Cholesterol/HDL Ratio:	
*Blood Pressure (mmHG):				*Blood Glucose (mg/dL):	
Health Care Provider Name:				NPI#:	
*Health Care Provider Signature: _____				*Date: _____	

Please send completed form in before 6/30/2014
Fax: 1-877-495-2746; **SECURE* Email to: PhysicianReportedForms@ashn.com
Mail to: Healthyroads ð Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040

*NOTE –

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INSTRUCTIONS:

1. Attend a preventive health visit with your Health Care Provider (HCP) within the dates specified on the top of the form. Provide this form to your HCP and ask them to complete Part II and sign the form after validating your screening results. You are responsible for any charges that may be incurred from your HCP as a result of completing this form.

2. Please Note: Laboratory reports should not be submitted.