2020 PCP Biometrics Screening Form

Dear Main Line Health Employee or family member:

Thank you for your interest in participating in this year's Making Life Healthy program! Your participation can yield improved health and valuable financial Rewards.

Here are the instructions for **submitting your results from a biometric screening with your physician**:

Step 1: Fill out the form

- Complete the **Patient** section of the attached participation form.
- Sign the Authorization line on the following page.
- **NOTE: This form cannot be processed without the authorization signed.**

Step 2: Complete a biometric screening with your physician

- Use results from a recent screening (no earlier than October 1, 2019), or schedule an appointment with your physician. If you are a new hire who had a recent biometric screening prior to this date, send an email to the Making Life Healthy mailbox.
- Have your physician complete and sign the **Health Care Provider** section.

Step 3: Review your form and make sure it is complete

- All fields are complete
  - Do not submit your form if any results are "pending"
- Your screening date is between 10/01/2019 and **09/01/2020**
- You have signed your form where it says "**SIGN HERE**"

Step 4: Submit your completed form (either fax or mail)

- Fax: 610-350-3530
- Mail: Impact Health, Attn: Data Dept.,1009 W. Ninth Avenue, Suite A, King of Prussia, PA 19406

NOTE – Please submit just the one page, no other pages/attachments are needed.

The program deadline is midnight on **September 1, 2020**.

Best of health!

Impact Health
Promoting Healthy Decisions

Physician Screening Form 2020

Patient: Please complete this section and sign the authorization below. (PRINT CLEARLY)

First Name:_____ Last Name:_____

Birth Date: ☐☐/☐☐/☐☐☐☐ Age: ☐☐

Employee ID #: _____ Gender: ☐ Male ☐ Female

Have you been diagnosed with diabetes or pre-diabetes? ☐ **Yes** ☐ **No**

Women only: Were you pregnant or nursing at the time of your screening? ☐ **Yes** ☐ **No**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my test results and my responses to the health questions at the top of this form to Active Health and the Delaware Valley Accountable Care Organization for the purpose of participation in Main Line Health's wellness program.

The Personal Health Information may be used or disclosed by Active Health and/or the Delaware Valley Accountable Care Organization for the following purposes:

(1) to provide me with programs and materials that I may find useful; and
(2) to contact me regarding health and wellness services.

I understand that I have the right to revoke this authorization at any time by delivering written notice of my intent to revoke to: Impact Health, 1009 West Ninth Avenue, Suite A, King of Prussia, PA 19406 Attention: Privacy Practices. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the Personal Health Information have acted in reliance upon this authorization. I understand that if I don't provide this authorization, I will not be eligible for Rewards for participating in the Making Life Healthy program.

This authorization is effective now and shall remain in effect for a period of one year, unless I revoke my authorization. I certify that I have received a copy of this authorization. I understand if I do not sign the authorization below, I am not eligible for program Rewards.

SIGN HERE → _____

Participant Signature (REQUIRED in order to process submission) Date

Health Care Provider: Please complete and sign this section.

Your patient is participating in a wellness program and has elected to have their biometric screening conducted by you. Please complete this section and **return it to your patient for them to submit** to the program.
(Please do not submit if any results are "pending")

Date of Screening ☐☐/☐☐/☐☐☐☐ (date must be between 10/01/2019 and **09/01/2020**)

Height (in feet and inches) ☐ feet ☐☐.☐ inches

Weight ☐☐☐.☐ pounds

Waist ☐☐.☐ inches

Blood Pressure ☐☐☐/☐☐☐ mmHg

Total Cholesterol ☐☐☐ mg/dL

HDL ☐☐☐ mg/dL

TC/HDL Ratio ☐☐.☐

Glucose ☐☐☐ mg/dL

Patient fasted for at least 8 hours prior to blood test? ☐ yes ☐ no

Health Care Provider Name: _____

Health Care Provider Signature _____

Health Care Provider phone: ☐☐☐-☐☐☐-☐☐☐☐ NPI:_____

Please return this completed form to Impact Health by 09/01/2020

Fax: **610-350-3530**
Mail: Impact Health, 1009 W. Ninth Avenue, Suite A, King of Prussia, PA 19406