



Health Screening Provider Form

- INSTRUCTIONS**
- PARTICIPANT - complete section 1
 - HEALTH CARE PROVIDER - complete section 2

SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed.

Participant's Date of Birth (MM/DD/YYYY) / / Gender M F Last 4 digits of SSN for the member primary on health insurance

Participant's First Name (MUST BE YOUR LEGAL NAME) MI Participant's Last Name (MUST BE YOUR LEGAL NAME)

Home or Work Address Unit/Apt

City State Zip Code

Personal or Work Email Address

Home, Work or Cell Phone Number - - Do you smoke: Yes No Are you (CHECK ONE): Employee Pensioner Spouse/DP Dep

Please read the following disclosure statement. I understand that my health screening data will be released to Summit Health for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer: however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to Alere, a vendor engaged by my Employer for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Wellness Assessment. The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: _____ Date: / /
(Month) (Day) (Year)

Date of Biometric Screening must be between 07/01/2014 and 04/30/2015 to receive completion credit. This form must also be completed in its entirety, accurately and legibly in order to be deemed complete.

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - for health care provider, physician or office staff use only below this line. Print clearly.

FOR HEALTH CARE PROVIDER: Courtesy of my employer, The State of Delaware, I have the opportunity to receive educational information about my personal biometric scores so that I can know my numbers and take steps to improve my health. I request that you provide my biometric data from this recent physical exam or screening to Summit Health.

Height <input type="text"/> ft <input type="text"/> in	Weight <input type="text"/> lbs	Body Composition <input type="text"/> BMI	Blood Pressure <input type="text"/> Systolic <input type="text"/> Diastolic
Blood Panel		Fasting Status (Check one)	
Total Cholesterol: <input type="text"/>	HDL: <input type="text"/>	TC/HDL ratio: <input type="text"/>	<input type="checkbox"/> Fasting
Triglycerides: <input type="text"/>	LDL: <input type="text"/>	Glucose: <input type="text"/>	<input type="checkbox"/> Non-Fasting
<input type="checkbox"/> I certify the listed biometric values are correct			

Facility Name: _____

Phone Number: _____ Date of Screening: _____

Health Care Provider's Name: _____

Health Care Provider's Signature: _____ Date Signed: _____

Date Faxed: _____

Please fax completed form to Summit Health at (248) 864-4409 by deadline 04/30/2015

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid

Have questions about the form or processing?

Please call Alere at (866) 674-9103