Primary Care Provider - Biometric Screening Incentive

Premise Health.

PARTICIPANT INSTRUCTIONS:

When utilizing your Primary Care Provider for the [2023] (year) incentive, this form must be completed to receive credit for your biometric screening and/or review appointment.

- Wellness Incentive steps must be completed between [1/1/22] (Incentive Date) [10/31/22] (Incentive Date).
- To be eligible for the incentive, please fax this completed form and a copy of your lab results to the [Butler Advantage Health & Wellness] (Client Name) Health Center at [5138962399] (Fax Number) by [10/31/22] (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

Please print clearly in CAPITAL LETTERS and fill out each blank space area using an ink pen (*required). Please complete the below information as noted, attach a copy of the lab results, and return to the patient for submission for their annual incentive program by [10/31/22] (Incentive Deadline).

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)	

PROVIDER INFORMATION:

Provider's Name: (print) _____

Provider's Signature: _____

Provider's Office Phone Number: _____

Provider's UPIN/NPI: _____