PREMERA BLUE CROSS

Healthcare Provider Biometric Screening Form

Metallic Wellness Program

SECTION 1 - EMPLOYEE INFORMATION - PLEASE ENTER YOUR INFORMATION

First Name | **MI** | **Last Name**

Date of Birth (Month) / (Day) / (Year) | **Gender** | **Member Medical ID #** | **Suffix**

Daytime telephone number | **Email Address**

SECTION 2 - OPTIONS - PLEASE SELECT OPTION A OR B

☐ **Option A - I WILL COMPLETE SECTION 3 and 4**
I have taken the lab values from my lab sheet and entered them into Section 3 of this form. I will fax my lab results with this form. Provider signature is not required if Option A is selected.

☐ **Option B - MY PROVIDER WILL COMPLETE SECTIONS 3 and 4**
I have seen my Provider and my Provider will enter all values listed in Section 3 and sign as required. Either myself or my Provider will fax completed form.

SECTION 3 - BODY MEASUREMENTS / BIOMETRIC RESULTS

Height ft in | **Weight** lbs | **Glucose** | **Fasting** Yes / No | **Blood Pressure** Systolic / Diastolic

Cholesterol
HDL: | TRI: | LDL: | Total:

Screening Date (Month) (Day) (Year)

Must supply new results each year to qualify

Screening for any values other than those listed in Section 2 may be subject to deductible, copay, and coinsurance.

SECTION 4 - PROVIDER INFORMATION - PLEASE ENTER PROVIDER INFORMATION WHO COLLECTED BIOMETRIC VALUES

Facility Name: _____

Provider's Name: _____

Phone Number: _____

Provider Signature: _____

SECTION 5 - EXCEPTIONS: FOR PROVIDERS ONLY

If in your professional and medical opinion it is unreasonable due to a medical condition for this patient to complete the biometric screening, please check the box below and sign and date.

☐ I certify this patient should not complete the biometric screening, due to a medical condition.

Provider Signature: _____

Date: _____

SECTION 6 - EMPLOYEE SIGNATURE - PLEASE SIGN AND DATE FORM

By signing and faxing this form , I understand that my data will be shared with my health plan or the administrator of the applicable wellness program. My individual results will **NOT** be shared with my employer. Premera is committed to maintaining the confidentiality of your medical information. For details about how we may collect, use and disclose your personal information and your rights regarding that information, please see our notice of privacy practices, available at www.premera.com.

Employee's Signature: _____ (Month) (Day) (Year)

SECTION 7 - CONFIRMATION - PLEASE CONFIRM (Check) YOU HAVE COMPLETED ALL SECTIONS AND ACTIONS

___ Section 1 - Employee information entered
___ Section 2 - Option A - Lab results faxed with completed and signed form
OR
Option B - This form collected from Provider after sections 3 and 4 are completed
___ Section 3 - All biometrics data entered by employee or provider
___ Section 4 - Provider information entered including provider signature if Option B
___ Section 5 - Form signed by employee
___ Completed form faxed to **1-855-351-6378** or emailed to **sgwellness@vivacity.net** ***Note: email is not considered a secure method for sending information.**
___ Copy of this form retained by employee
For questions regarding the wellness program contact Premera Blue Cross customer service.

FORMS CANNOT BE PROCESSED UNLESS ALL SECTIONS ARE COMPLETED AND THE FORM IS SIGNED.

PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Español (Spanish): Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese): 本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Tiếng Việt (Vietnamese): Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).