State of Rhode Island
Health Rewards Program
Biometric Screening Physician Form

To receive incentive co-share credit this form must be completed by your primary care physician and returned to UnitedHealthcare by February 20, 2009.

Employee Information (to be completed by employee)

Name (please print) _____

UHC Subscriber ID (on UHC card) OR SSN _____

Date of Birth _____

Preventive Screening Verification (to be completed by physician)

_____ (date) Blood Pressure Diastolic _____ Systolic _____

_____ (date) Body Mass Index (BMI) Height _____ ft _____in Weight _____lbs
BMI _____

_____ (date) Body Fat _____ %

I certify that the patient named above has received the above biometric screenings at my office.

Signature: _____ Date:_____

Name of Physician (please print) _____

Physician address: _____

_____

_____

Physician telephone: _____

* In accordance with HIPAA, no personal health information will be shared with the State of Rhode Island.

Return completed forms to:

Linda Lynch
UnitedHealthcare
475 Kilvert Street
Warwick, RI 02886

Or drop off at any onsite health fair
January 1 – February 20, 2009

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