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Health Care Provider Biometric Screening Form

INSTRUCTIONS

- **MEMBER- Completes Sections 1, 2 AND 5.**
- **PROVIDER-If patient chooses Option B, complete all areas in Section 3 and Section 4.**
- **FAX-To Vivacity at 425-918-5075 or toll free at 1-877-657-4183 or scan and email your form to wcif@vivacity.net**

SECTION 1 - MEMBER INFORMATION

Date of Birth (Month) (Day) (Year)

Medical ID #

First Name

MI

Last Name

Daytime contact phone number including area code ___ ___ ___ ___

STATUS (check one box)

Employee

Spouse/Domestic Partner

SECTION 2 - OPTIONS

☐ **Option A**
I have taken the lab values from my lab sheet and entered them into Section 3 of this form, making sure all areas are complete. I will fax my lab slip with this form to Vivacity.

☐ **Option B**
I have seen my provider and my provider will enter all values listed in Section 3, complete Section 4 and fax to Vivacity.

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)

****Note- Lab screening date must be after 11/15/2012**

SECTION 4 - PROVIDER INFORMATION

Facility Name: _____

Provider's Name: _____

Phone Number: _____

Provider Signature: _____

****Note- Only required if you are not submitting your actual lab documents**

SECTION 5 - MEMBER SIGNATURE

By faxing this form to Vivacity, I agree to allow my data to be shared with my health plan or any other administrator of the applicable wellness program. My individual data will **NOT** be shared with my employer.

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

Please fax completed form to Vivacity at 425-918-5075 or toll free at 1-877-657-4183.
You may also scan and email your form to: wcif@vivacity.net
Please retain a copy for your records.