U.S. Preventive Medicine

Physician/HealthCare Professional Lab & Biometric Certification Form

This form is for employees/members who are reporting results from a Lab & Biometric Screening with a Primary Care Provider obtained within 90 days of completing the Health & Well-Being Assessment. It is for use by members that do not attend an employer sponsored onsite screening event and are not able to visit an approved offsite lab.

TO BE COMPLETED BY PARTICIPANT

Name: (Print) _____

Telephone #: (____) _____ ext. _____ Date of Birth: ____/____/____
MM DD YYYY

Privacy Statement: USPM is committed to protecting the privacy and confidentiality of employee information. We follow all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA). Strict measures have been taken to protect all personal information.

Authorization to Release Information: I hereby authorize the medical healthcare provider listed below to release the health information detailed below for the sole purpose of completing the Biometric Health Screening for The Preventive Plan.

Participant Signature: _____ Date: ____/____/____
MM DD YYYY

TO BE COMPLETED BY HEALTHCARE PROVIDER

****Enter *ONLY* measurements taken within 90 days of completing your HWA****

***Height:** _____ in. ***Weight:** _____ ***Waist:** _____ In.

***Blood Pressure:** _____

***Total Cholesterol:** _____

***HDL Cholesterol:** _____

***LDL Cholesterol:** _____

***Triglycerides:** _____

***Blood Glucose:** _____

* = required measurements

Provider Name (Print): _____ Address: _____

Physician NPI #: _____ _____

Telephone #: (____) _____ _____

Fax #: (____) _____

Provider Signature: _____ Date: ____/____/____
MM DD YYYY

To upload your Provider Certification Form, locate the "Upload Provider Certification Form" button on the "My Health" tab. Upload your Provider Certification Form *after* completing your Health & Well-Being Assessment (HWA). Need more help? Call Member Care at 866.713.1180

The PREVENTIVE Plan
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