



Biometrics Screening Results | Health Care Provider Form



University of Alaska is providing the opportunity for eligible members to submit biometrics screening results from your Health Care Provider (HCP) to participate in the screening component of your incentive program. Please refer to the Instructions on the following page.

The date of your screening must occur on or after 7/1/2013 and this form must be completed and received by Healthyroads on or before 6/30/2014 to be eligible for the biometric screening component of your incentive program.

Please print neatly. Incomplete or illegible forms will not be processed and you will not receive incentive credit. Write your first and last name exactly the way that they appear on your payroll stub and/or your medical benefits card. PLEASE NOTE: Values below with an asterisk (*) are *required*. This form will not be processed if any required values are missing. Fax completed form to:

1-877-495-2746 by 6/30/2014

PART I To be completed by Eligible Member	
Employer Group: University of Alaska	Relation to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner
*First Name:	*Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	*Date of Birth (MM/DD/YYYY): / /
Phone Number:	Email Address:

MEMBER ATTESTATION/AUTHORIZATION: By submitting this form, I am authorizing my HCP to report my laboratory and biometric results to Healthyroads to be included as pa23..8 475.75 il om3l|Wlude8(77.55 Tm0 g(HC)).t3.64 3By submitting this form, I am authorizing m3#FTy#Hv0H

		<input type="checkbox"/> Yes <input type="checkbox"/> No	*Total Cholesterol (mg/dL):
Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		*LDL (mg/dL):
Waist Circumference (in):			*HDL (mg/dL):
*Weight (pounds):			*Triglycerides (mg/dL):
*Height:	ft	in	Total Cholesterol/HDL Ratio:
*Blood Pressure (mmHG):			*Blood Glucose (mg/dL):
Health Care Provider Name:			NPI#:
*Health Care Provider Signature: _____			*Date: _____

Please send completed form in before 6/30/2014

Fax: 1-877-495-2746; *SECURE Email to: PhysicianReportedForms@ashn.com

Mail to: Healthyroads | Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040

*NOTE -

