Physician Screening Form

University of Arkansas System (UAS)

Biometric Health Screening Reward Requirements:

► If you are unable to attend an onsite health screening event, you may submit screening results **collected by your health care provider** by submitting this form to your health care provider and returning it to Onlife Health by **09/30/2017**

► Physicals and blood work must be completed between **May 1, 2017** and **September 30, 2017** for incentive credit.

► Please allow up to 6 weeks for processing.

I, the undersigned, understand that my employer is the Plan Sponsor of my Group Health Plan and may receive a list of my participation for administrative purposes, including but not limited to, billing and attendance. I understand that my Group Health Plan is administered by UMR, Inc. and my Group Health Plan's wellness program is administered by Onlife Health, Inc. UMR, Inc. and Onlife Health, Inc. may have access to my individually identifiable information for condition management purposes, or to appropriately operate or administer my Group Health Plan. The organizations involved in this wellness activity recognize the importance of safeguarding individually identifiable health information and are legally obligated to take all reasonable steps to protect such information.

Name (First, Middle Initial, Last):_____

Signature of consent to participate: _____

Marking Instructions: The following pages are to be completed by your health care provider. They may use an ink pen to write the value(s) on the appropriate line(s) AND to fill in the corresponding bubbles. Please be sure that both are complete to ensure this form can be quickly and accurately processed and participation recorded. Do not forget to include this cover sheet and consent with the form attached.

Submit the completed Biometric Health Screening form to Onlife Health:

► Email: bioforms@onlifehealth.com. Immediate electronic confirmation will be provided for email submissions.

► Fax: 615.844.2128

► US Mail: Onlife Health, Attn: Onlife Health, 9020 Overlook Blvd., Suite 300, Brentwood, TN 37027

► **Results must be submitted *by September 30, 2017.***

Questions? Call a Participant Service Representative at 1.877.369.0285

Onlife HEALTH

Biometric Screening Form

AID (OLH Use Only):

Name (First, Middle Initial, Last):

Patient Email:

Telephone

0	0	0		0	0	0		0	0	0	0
1	1	1		1	1	1		1	1	1	1
2	2	2		2	2	2		2	2	2	2
3	3	3		3	3	3		3	3	3	3
4	4	4		4	4	4		4	4	4	4
5	5	5		5	5	5		5	5	5	5
6	6	6		6	6	6		6	6	6	6
7	7	7		7	7	7		7	7	7	7
8	8	8		8	8	8		8	8	8	8
9	9	9		9	9	9		9	9	9	9

Date of Birth

0	0		0	0		0	0
1	1		1	1		1	1
	2		2	2		2	2
	3		3	3		3	3
	4			4		4	4
	5			5		5	5
	6			6		6	6
	7			7		7	7
	8			8		8	8
	9			9		9	9

Height (ft) (in)

0	0		0	0
1	1		1	1
2	2			2
3	3			3
4	4			4
5	5			5
6	6			6
	7			7
	8			8
	9			9

Weight (lbs)

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
	8	8
	9	9

Waist Measurement (in)

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
	8
	9

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Gender
○ Male ○ Female

Fasting Status
○ Fasting ○ Non-Fasting

Date of Exam
__ __ – __ __ – __ __

Resting Pulse

0	0	0
1	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

Blood Pressure

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3		3	3
	4	4		4	4
	5	5		5	5
	6	6		6	6
	7	7		7	7
	8	8		8	8
	9	9		9	9

Glucose

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

Total Cholesterol

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

HDL

0	0	0
1	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

LDL

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

Triglycerides

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Tobacco-Free Pledge: My patient states that he/she **has not used** tobacco products in the last 3 months.	
○ Yes	○ No

Health Care Provider Name

Health Care Provider Signature

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