Physician Screening Form

Ascend to Wholeness Healthcare Plans

Physicals & blood work should be completed between January 1, 2019 and July 31, 2019 to enroll in the 2020 Accelerate Plan.

PLEASE USE ONE METHOD FOR SUBMITTING YOUR RESULTS by July 31, 2019:

e-mail:	***offsiteforms@interactivehealthinc.com***
Fax:	***(410) 356-6205***
US Mail:	***Interactive Health*** ***Attn: Alternative Means*** ***11409 Cronhill Drive, Suite M*** ***Owings Mills, MD 21117***

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

SECTION I: ***TO BE COMPLETED BY HR***

_____ is authorized to use the Alternative Means method of completing the Biometrics Screening prior to July 31, 2019.

HR Representative's Signature: _____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOU*** **(PLEASE PRINT)**

First & Last Name: _____ Gender: ☐Male ☐Female

Member ID: _____ Date of Birth: _____ Relationship: ☐Employee ☐Spouse

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: (_____) _____

I understand that my personally identifiable health information will be obtained by Interactive Health Solutions Inc. and/or its subsidiary Health Solutions Services, Inc. (IH) through the submission of this form and hereby consent to IH receiving such information. IH will hold my personally identifiable health information confidential; and it will not be shared with my employer; however, my employer may be advised of the fact of my participation. I give permission to IH to share such information with the health plan sponsoring this program, and other health management providers determined by the sponsoring health plan for the purpose of receiving services under the Wellness Program.

Signature: _____ Date: _____

SECTION III: ***TO BE COMPLETED BY PHYSICIAN***

Examination and Blood Work Date: _____ (must be between 01/01/2019 and 07/31/2019 for credit)

Height: _____ feet _____ inches Weight: _____ pounds Blood Pressure: _____ / _____ mg/Hg

Total Cholesterol: _____ mg/dl HDL: _____ mg/dl Total Cholesterol / HDL Ratio: _____

Triglycerides: _____ mg/dl LDL Cholesterol: _____ mg/dl Glucose: _____ mg/dl

Physician Signature: _____ Date: _____

Physician's Information: First & Last Name: _____

Address: _____

_____

Phone Number: (_____)_____