2022 Outside Provider Biometric Screen Form

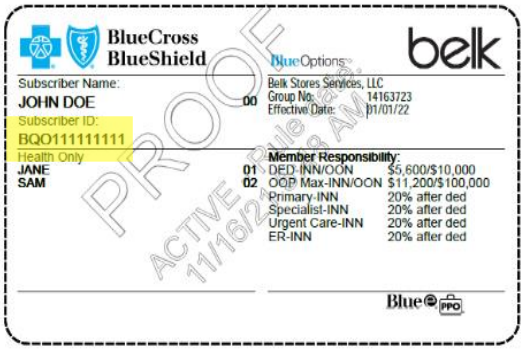
Dear Belk Participant:

Please use this form for your biometric screen. Please complete the top section (Patient information) and then review this document prior to your appointment. During the visit with your health care provider, please discuss preventative care and be sure to inquire about traditional recommended screenings. Ensure your provider completes the biometric results, signs/dates form. After your visit, you or your provider will submit this form to Marathon to be eligible for incentives. Forms can be submitted to Marathon Health via fax, email, or mail. *Contact information is located at the bottom of the page*. **Your biometric screen must be completed and submitted between January 1, 2022 and November 15, 2022. Please note, Marathon Health may use and disclose your personal identifiable information obtained on this form, including, but not limited to, your name, date of birth, and screening results (your "Personal Information") to provide health management services to you from BCBSNC. Please direct all incentive and insurance plan questions to BCBSNC at 800-422-2717.**

ALL PATIENT INFORMATION IN THIS SECTION IS REQUIRED IN ORDER FOR THE FORM TO BE PROCESSED.

Patient First & Last Name:_____ Patient Date of Birth:_____/_____/_____
(Please Print)

Subscriber ID#: _____ (Found on Insurance Card)



Dear Health Care Provider: Your patient is participating in an employer- sponsored wellness program that provides financial incentives. To earn the incentives, your patient will need to obtain the biometric measures listed below to complete this form. Upon completion, please return this form to your patient or send directly to Marathon Health, via the contact information listed at the bottom of page.

Date and Time of Biometric Screen: ___/____/___Time: _____
(This date must be between January 1, 2022 and November 15,2022)

SECTION I: BIOMETRIC RESULTS – This section must be completed in its entirety.

ANNUAL HEALTH SCREENING CRITERIA	RESULTS
FASTING	Yes No
TOBACCO USER	Yes No
BODY MASS INDEX (BMI)	Height _____"in. Weight_____lbs. BMI_____. ____
WAIST CIRCUMFERENCE	Value:_____"in.
BLOOD PRESSURE	Value:_____/_____mm HG
TOTAL CHOLESTEROL	Value: _____ mg/dL
HDL CHOLESTEROL	Value: _____ mg/dL
TRIGLYCERIDES	Value: _____ mg/dL
LDL CHOLESTEROL	Value: _____ mg/dL
TOTAL CHOLESTEROL TO HDL RATIO	Value:_____. _____
BLOOD SUGAR	Value: _____ mg/dL

□ **I affirm that the information provided is true and correct to the best of my knowledge.**

Healthcare Provider Name (please print):_____Phone: _____

Healthcare Provider Signature:_____Date:_____UPIN/NPI: _____

Please fax, email, or mail this form to Marathon Health, using the information below. You must submit your biometric results no later than November 15, 2022.
Due to private health information, Email is not considered a secure method of transmission.
All data fields are required to submit this form for incentive completion.

Fax: 866-422-0915 | member@marathon-health.com | 10 West Market St., Ste 2900, Indianapolis, IN 46204