Belk Stores

Outside Provider Biometric Screen Form

Dear Belk Participant:

Please use this form for your biometric screen. Please complete the section between the blue lines 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. After your visit, submit this form to OurHealth 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, 2021 and September 30, 2021**

Please note, Marathon Health may use and disclose your personally 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)

Gender:_____Subscriber ID#: _________________________ (Found on Insurance Card)

BlueSelect
Subscriber Name:
JOHN SAMPLE
Subscriber ID:
YPXW12345678
01 Group No: 083708
Rx Bin: 015905
Date Issued: 01/01/19
In-Network Member Responsibility:
Primary $25
Specialist Tier 1/2 $50/$75
Urgent Care $50*
ER $250*
Coins Tier 1/2 20%/40%
Prescription Drug Benefits Included
*Same for out-of-network
DentalBluePreferred
PPO
℞ C4

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.

***Instructions for provider use: Glucose (CPT 82947) and fasting lipid panel (CPT 80061) are required to qualify for incentives.**

Date and Time of Biometric Screen:________/___________/________Time: ____________

(This date must be between January 1, 2021 and September 30, 2021)

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

Screening Test	Result
BMI Height Weight Waist Circumference	BMI:___________ Height ____________ in. Weight____________ lbs Waist ___________ in.
Blood Pressure	__________ / __________ mm HG
Blood Glucose Fasting? ☐ Yes ☐ No	______________ mg/dL
Lipid Panel	LDL ______________ mg/dL HDL _______________ mg/dL Total Chol. ______________ mg/dL Triglycerides ______________ mg/dL
Tobacco Attestation	☐ Yes ☐ No

☐ 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 September 30, 2021. ***All data fields are required to submit this form for incentive completion.***

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