MEABT BIOMETRIC HEALTH SCREENING
Please check with your insurance provider before scheduling your screening to ensure it is covered under your plan for this year.
You will be responsible for any fees associated with the screening if it is not covered by your insurance.

SECTION 1: TO BE COMPLETED BY YOU (PLEASE PRINT)

Last Name

First Name (Legal Name, No Nicknames)

Birth Date (06221975)

Email Address

Preferred Phone Number (no spaces)

Please read the disclosure statement: I understand my individually identifiable information may be shared with and used by Onlife Health to populate health assessment data and to provide health management services including data aggregation for program improvement purposes. Such information will not be used for any other purpose. I understand that my individually identifiable health information will not be shared with MEABT; however MEABT will be advised of the fact of my participation in the Know Your Numbers campaign. The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Signature: _____   Date: _____ / _____ / _____

Biometric Health Screening Reward Requirements
Medically covered participants, spouses and dependents age 18 and older are eligible to receive points for the Biometric Health Screening.
►Screening must be completed between **06/01/2016** and **05/31/2017**.
►Forms must be received **by 05/31/2017**. Any form received after this date will be held until the next program year.
Submit the completed Biometric Health Screening form by one of these methods to Interactive Health:
►Email: offsiteforms@interactivehealthinc.com   immediate electronic confirmation will be provided for email submissions.
►Fax: 410-356-6205
►US Mail: Interactive Health/Alternative Means, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117
►Please allow up to 6 weeks for processing; points are reflected on Onlife Health website. If you have questions regarding this form, please contact Interactive Health at 800-711-8656. If you have questions regarding the incentive, or need additional assistance please contact Onlife at 1-877-806-9379, option 1.

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN (PLEASE PRINT)

►**All information must be provided before you will receive any points. Screening must take place between 06/01/2016 and 05/31/2017 to be eligible for points.**
► **MEDICARE RECIPIENTS – Ask your doctor to use your most recent screening numbers if it's not time for new blood work.**

Examination Date: ____ / ____ / _____   Height: _____   Weight: _____ lbs.

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

LDL Cholesterol: _____ mg/dl   Triglycerides: _____

Glucose Level: _____ mg/dl   Hours Fasting: _____

Blood Pressure: _____ / _____ mm/Hg

Physician's Signature or stamp: _____

Physician's Name (please print): _____

Physician's Address: _____