Biometrics Screening Results – Health Care Provider Form

University of Alaska is providing the opportunity for eligible members to submit biometrics screening results from your Health Care Provider (HCP) to participate in the screening component of your incentive program. Please refer to the Instructions on the following page.

The date of your screening must occur on or after **7/1/2013** and this form must be completed and received by Healthyroads on or before **6/30/2014** to be eligible for the biometric screening component of your incentive program.

Please print neatly. Incomplete or illegible forms will not be processed and you will not receive incentive credit. Write your first and last name exactly the way that they appear on your payroll stub and/or your medical benefits card. PLEASE NOTE: Values below with an asterisk (*) are *required*. This form will not be processed if any required values are missing. Fax completed form to:
1-877-495-2746 by 6/30/2014

PART I – To be completed by Eligible Member	
Employer Group: **University of Alaska**	Relation to Employee: ☐ Self ☐ Spouse/Domestic Partner
*First Name:	*Last Name:
Gender: ☐ Male ☐ Female	*Date of Birth (MM/DD/YYYY): / /
Phone Number:	Email Address:

MEMBER ATTESTATION/AUTHORIZATON: By submitting this form, I am authorizing my HCP to report my laboratory and biometric results to Healthyroads to be included as part of my employer–sponsored biometrics screening. I have provided this form to my HCP and authorize him or her to send the requested results to Healthyroads. I authorize Healthyroads to contact my HCP to validate the results, if necessary as determined by Healthyroads. I attest that I have read and agreed to the Use and Disclosure Statement on the following page.

*Member Signature:______________________________ Date:______________

PART II – To be completed by Health Care Provider

Your patient's employer (or spouse's or domestic partner's employer) is encouraging all of its members to take an active role in managing their health by completing a biometric screening. Please complete all sections of Part II of this form, sign, and submit according to the instructions below.

*Date of Screening: (No earlier than **7/1/2013**)		*Fasting?	☐ Yes ☐ No	*Total Cholesterol (mg/dL):	
Pregnant?	☐ Yes ☐ No			*LDL (mg/dL):	
Waist Circumference (in):				*HDL (mg/dL):	
*Weight (pounds):				*Triglycerides (mg/dL):	
*Height:	ft in			Total Cholesterol/HDL Ratio:	
*Blood Pressure (mmHG):				*Blood Glucose (mg/dL):	
Health Care Provider Name:				NPI#:	

*Health Care Provider Signature: ______________________________ *Date: ______________

Please send completed form in before 6/30/2014
Fax: 1-877-495-2746; *SECURE Email to: PhysicianReportedForms@ashn.com
Mail to: Healthyroads – Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040

*NOTE – This email address is for incoming forms only. Please do not send questions, status inquiries, or emails to this inbox. Inquiries can be directed to Healthyroads at 1-877-330-2746 or emailed to Healthyroads at service@healthyroads.com

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Healthyroads

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INSTRUCTIONS:

1. Attend a preventive health visit with your Health Care Provider (HCP) within the dates specified on the top of the form. Provide this form to your HCP and ask them to complete Part II and sign the form after validating your screening results. You are responsible for any charges that may be incurred from your HCP as a result of completing this form.

2. Please Note: **Laboratory reports should not be submitted. Healthyroads will not review laboratory reports** to obtain and process data values. Healthyroads will only process data entered on this form by your HCP. Any laboratory reports that are submitted will be shredded by Healthyroads upon receipt.

3. Make a copy of the form for your records. Forms must be received by the deadline printed on the top of the form.

4. Please be sure the form is complete and legible. Incomplete forms will not be processed. Fax, email ***securely***, or mail completed forms:
   - Fax Number: 1-877-495-2746
   - Email Address: PhysicianReportedForms@ashn.com
   - Mailing address: Healthyroads – Attn: BIO DATA-C4-1, P.O. Box 509040, San Diego, CA 92150-9040.

5. Your screening data will be viewable on www.healthyroads.com under My Programs/Biometrics Screening and will also be submitted to your incentives program within 30 calendar days of receiving your completed form, but no earlier than the start of your company's Healthyroads program. (Member-level biometric results will not be shared with your employer.) Once your form has been processed, you will receive notification via email (if valid email address is provided) that your data is viewable on Healthyroads.com. You can view your data and get customized recommendations for improvement by going to the Personal Scorecard tab after logging in to the website.

6. If you have questions about your incentive criteria, please contact your Human Resources Department. For any questions related to this form, please call Healthyroads at 1-877-330-2746 or email Healthyroads at service@healthyroads.com

Healthyroads® Biometric Assessment Information Use and Disclosure Statement

Healthyroads, Inc. and its affiliates or subsidiaries as well as their successors, assignees, and licensees (hereinafter "Healthyroads") may use and/or provide the information relating to the biometric assessment tests to your plan sponsor or health plan, as applicable, to administer your plan. In addition, Healthyroads may also use your personal information obtained through the biometric assessment results form to provide you with information about other health-related benefits available to you through your plan sponsor or health plan, as applicable. That data may also be used to populate your online tools and trackers on Healthyroads.com, which may be used by your Healthyroads Coach® in connection with the Healthyroads Coaching Program if that program is available to you and you choose to participate in it. Provision of the information noted above to your plan sponsor, health plan, or other entities, as applicable, that have contracted with your plan sponsor or health plan to administer your plan, is intended for purposes related to treatment, payment (billing, eligibility) or operational and administrative requirements. Such purposes will vary by entity, but may include, eligibility for incentives due to participation in the program, quality control and auditing purposes, and facilitation with case management or disease management programs available from your plan sponsor or health plan, as applicable. In these situations, Healthyroads requires recipients of the information to ensure that there are safeguards in place so that personal information is only used for the purposes noted. If information is disclosed to plan sponsors who are employers, then such information is required to be used for benefit administration purposes only.

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