PREMERA BLUE CROSS

Health Care Provider Biometric Screening Form

vivacity

INSTRUCTIONS

- **EMPLOYEE - Completes Sections 1, 2 AND 5.**
- **PROVIDER - If patient chooses Option B, complete all areas in Section 3 and Section 4.**
- **FAX - To Vivacity at 425-918-5075 or toll free at 1-877-657-4183.**

SECTION 1 - EMPLOYEE INFORMATION

Date of Birth (Month) / (Day) / (Year)

Arctic Number

Gender M/F

First Name

MI

Last Name

SECTION 2 - OPTIONS

☐ **Option A**
I have taken the lab values from my lab sheet and entered them into Section 3 of this form, making sure all areas are complete. I will fax my lab slip with this form to Vivacity.

☐ **Option B**
I have seen my provider and asked my provider to enter all values listed in Section 3, complete Section 4 and fax to Vivacity.

****NOTE - Lab values will not be accepted if collected prior to 8/1/2012**

SECTION 3 - BODY MEASUREMENTS / BIOMETRIC RESULTS

Height ft in

Weight lbs

Glucose

Fasting Yes No

Blood Pressure Systolic / Diastolic

Cholesterol

HDL:

TRI:

LDL:

Total:

Screening Date: (Month) (Day) (Year)

SECTION 4 - PROVIDER INFORMATION

Facility Name: _____

Provider's Name: _____

Phone Number: _____

Provider Signature: _____

SECTION 5 - EMPLOYEE SIGNATURE

By signing and faxing this form to Vivacity, I agree to allow my data to be shared with my health plan or any other administrator of the applicable wellness program. My individual data will **NOT** be shared with my employer. Form will not be accepted without signature.

Participant's Signature: _____ (Month) (Day) (Year)

Please fax completed form to Vivacity at
425-918-5075 or toll free at 1-877-657-4183.
Please retain a copy for your records.
You may verify receipt of your fax by emailing alaskaairgroup@vivacity.net.