2018 EMHS Biometric Provider Form

SECTION 1: EMPLOYEE INFORMATION – REQUIRED

Please provide employee information in this section. If your spouse/domestic partner is also participating, please complete section 1 and then list them in section 2 below. Please print clearly to ensure your information can be processed for your EMHS biometric reward. Questions about this form should be directed to Beacon Health at beaconwellness@emhs.org

Employee Name:	**Employee ID:**
Employee Date of Birth:	**Employer/Affiliate:**
☐ Please check this box if you would like an email confirmation receipt of this form. (Email address field is required).	**Email Address:**

SECTION 2: SPOUSE/DOMESTIC PARTNER INFORMATION: If both employee and spouse/domestic partner are participating, a separate form should be completed for each participant.

Full Name:	**Date of Birth:**

SECTION 3: PATIENT INFORMATION – TO BE COMPLETED BY THE PROVIDER:

An EMHS biometric reward will be provided to employees and/or spouses/domestic partners, covered by the EMHS Employee Health Plan, who complete a biometric screening (or provide their biometric values via this form).

Please provide value and date collected:

LDL: **Date:**	**Fasting Glucose:** **Date:** **OR** **HgA1C:** **Date:**	**BP:** **Date:**
Height (in): **Date:**	**Weight (lbs):** **Date:**	**BMI:** **Date:**
Primary care provider (PCP) signature:		
Printed name of provider: (Must be legible)		
Name of provider's practice:		**Today's Date:**

It is the responsibility of the employee to verify receipt by Beacon Health and to verify that Beacon has received it. Please return this form to Beacon Health by one of the following:

Fax to: Beacon Health
207-989-1096

Mail to: Beacon Health Wellness
797 Wilson Street
Brewer, Maine 04412

Email: beaconwellness@emhs.org

Beacon Health
EMHS MEMBER℠