EMHS Biometric Provider Form

STEP 1: EMPLOYEE INFORMATION – To be completed by *EMPLOYEE*:
Please provide employee information in this section. Please print clearly to ensure your information can be processed for your **EMHS Biometric Screening Program** 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:**
Email Address:	

STEP 2: PATIENT INFORMATION – To be completed by *PATIENT*: Patient may be employee or spouse/domestic partner. If both are participating, a separate form should be completed for each patient.

Patient Full Name:	**Date of Birth:**

STEP 3: PATIENT INFORMATION – To be completed by *PROVIDER*:
A **EMHS Biometric Screening Program reward** will be provided to employees and/or spouses/domestic partners, covered under the EMHS employee health plan, who meet the criteria.

Please provide value and date collected:

	Results	Date of Service		Results	Date of Service
Blood Pressure	/		Glucose Fasting/ HbA1C		
Height (inches)			LDL		
Weight (pounds)			HDL		
Tobacco User (please circle one): Yes No			Total Cholesterol		
Printed Name of Provider (must be legible)			Name of PCP's Practice:		
Primary Care Provider Signature:					

It is the responsibility of the employee to verify that Beacon has received this form. Provider forms must be received by Beacon Health no later than December 31, 2018. Please return this form to Beacon Health by one of the following:

Fax to: Beacon Health (207) 973-7165 **Email:** beaconwellness@emhs.org

Beacon Health
EMHS MEMBER℠