Northern Light Beacon Health Employee Health Plan

2019 Biometric Program 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 **Northern Light Health Biometric Screening Program** reward. Questions about this form should be directed to Beacon Health at beaconwellness@northernlight.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. 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 **Northern Light Health Biometric Screening Program** reward will be provided to employees and/or spouses covered under the Northern Light Health Employee Health Plan, who meet the criteria.

Please provide value and date collected:

	Results	Date of Service		Results	Date of Service
Blood Pressure	/		LDL		
Height (inches)			HDL		
Weight (pounds)			Total Cholesterol		
Glucose Fasting/ HbA1C					
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 November 30, 2019 by one of the following:

Fax to: Beacon Health
207-973-7165

Employees: You can upload the form at https://beaconhealthwellness.org/.