PCP FAX FORM – ASANTE HEALTH PROMOTION SERVICES

ASANTE Physician Partners

To my Primary Care Provider,
As part of Asante's Know Your Numbers wellness program, I have the opportunity to receive wellness program information so I can take steps to improve or maintain my health. I request that you complete Sections 2 through 4 below, based on my recent preventive examination, and fax it to **Asante Health Promotion** 541-789-4060 before December 11, 2020 you may contact them with questions at 541-789-4995.

Section 1 - TO BE COMPLETED BY PARTICIPANT

Participant's First Name ☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐ Participant's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Participant's Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐ Age ☐☐ Gender ☐ M ☐ F

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Unit/Apt. ☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip Code ☐☐☐☐☐

Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Check all that apply

☐ **I am an Asante Employee Employee ID#:** ☐☐☐☐☐☐

☐ **I am the spouse/domestic partner of _____, an Asante Employee** ☐☐☐☐☐☐
(please provide Asante employee's name) Employee ID#

Participant disclosure statement: I understand that my biometric values will be released to health plans associated with Asante for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with Asante; however Asante may be advised of the fact of my participation in this biometric screening for purposes of qualification for incentives offered by Asante. My biometric screening values may be disclosed to vendors engaged by Asante or Asante's sponsored group health plan, including Asante Health Promotion Services, Regence Blue Cross Blue Shield and their affiliates and subsidiaries, for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes. The importance of safeguarding individually identifiable health information is recognized and all organizations involved in the Know Your Numbers wellness program are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: _____ Date: _____

Section 2 - TO BE COMPLETED BY PCP - Please print firmly in ink.

Height ☐ ☐☐ (Feet / Inches) Weight ☐☐☐ (Pounds) Body Mass Index ☐☐ Blood Pressure ☐☐☐/☐☐☐ (Systolic / Diastolic) Pulse/Heart Rate ☐☐☐ (Beats/minute)

Total Cholesterol ☐☐☐ HDL ☐☐☐ TC/HDL Ratio ☐☐.☐ TRIG ☐☐☐ LDL ☐☐☐☐

Fasting Glucose ☐☐☐ Non-Fasting ☐☐☐ Waist Circumference ☐☐☐☐

Section 3 – STATEMENT OF MEDICAL CONDITION REQUIRING ALTERNATIVE METHOD

This section only needs to be completed if, due to an existing medical condition, certain biometric values cannot be obtained and documented. The program allows a reasonable alternative standard or method for obtaining the incentive to any individual for whom it is unreasonably difficult due to a medical condition or it is medically inadvisable to obtain certain biometric values. Please list any applicable medical conditions for this patient that prevents certain biometric values from being obtained and documented:_____

Section 4 - LICENSED MEDICAL PROFESSIONAL SIGN-OFF

Date of Examination: _____ Facility Name: _____ Phone Number: _____

I VERIFY THAT THE INFORMATION IN SECTIONS 2, 3 AND 4 IS COMPLETED AND ACCURATE.

Name of PCP: _____ Signature: _____

Date Signed: _____

INCOMPLETE, INACCURATE, OR ILLEGIBLE FORMS WILL BE DEEMED INVALID.