HM.7 - PROVIDER DATA ENTRY FORM

PARTICIPANT (PERSON BEING MEASURED)

Name:

DOB: **Last 4 SSN:** **Member ID:**

SUBSCRIBER

Name:

DOB: **Last 4 SSN:** **Member ID:**

By submitting this form, I am authorizing my physician to report the laboratory and biometric results to MedExpert for my Biometric Labs and Tests, and for UFCW Trust to collect such information.

1. *You, the participant, are responsible for meeting all program deadlines. You, the participant, must collect this form from your physician or clinician and submit to MedExpert as prescribed. Only one physician form can be submitted per person.*
2. *See the program description in your enrollment materials for more details. Please keep a copy of this physician-completed form for your records.*

Participant's Signature: _____ **Date:** _____

FOR PROVIDER OR OFFICE STAFF USE ONLY BELOW THIS LINE

Height ☐☐ ft ☐☐ in

Weight ☐☐☐ lbs

Test Date ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

Blood Pressure ☐☐☐ Systolic ☐☐☐ Diastolic

Test Date ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

Cholesterol

HDL: ☐☐☐ TRI: ☐☐☐

LDL: ☐☐☐ Total: ☐☐☐

Test Date ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

Glucose

☐☐☐ Fasting

☐☐ • ☐☐ A1c

Test Date ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

Nicotine User? (Optional)

◯ Y ◯ N

Test Date ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

NOTE: Facility name is optional. Please print clearly.

◯ I certify these values are correct

Facility Name: _____

Certifying Agent First Name: _____

Last Name: _____

NPI#: ☐☐☐☐☐☐☐☐☐☐

Today's Date: ☐☐ • ☐☐ • ☐☐☐☐ (Month) (Day) (Year)

Provider's Signature: _____

Participant Contact Information:

Phone: ☐☐☐ • ☐☐☐ • ☐☐☐☐

HM7

Provider: Please return form to participant, or fax to 1-650-326-6700.
Participant: Upload form at MedExpert's website - log in at www.ufcwtrust.com and click your Wellness Steps button to access.

For more information, call MedExpert at 1-800-999-1999