2020 Provider Form

Employees and spouses enrolled in a medical plan sponsored by the State Personnel Department are eligible for a $100 e-gift card reward for completing a biometric screening. This form can be completed by your healthcare provider to earn your biometric screening reward.

Required measurements must be taken in 2020. Forms must be fully completed and processed by **November 30, 2020** to earn the reward. **Please note, it can take up to four weeks for forms to be processed.** Your form is considered processed when the ActiveHealth portal Rewards Center shows the activity as complete.

Participant instructions

Step 1: **Make An Appointment**

Set up your appointment with the provider of your choice. When you make your appointment tell the provider what measurements you need. The required measurements are height, weight, waist circumference, blood pressure, total cholesterol, HDL, LDL, triglycerides, blood glucose, and optional HbA1c.

Step 2: Fill out Section 1: Participant Information. Don't forget to sign it.

Step 3: **Take this form with you to your appointment.** Your provider must fully complete Section 2: Results and Provider Information.

Step 4: **Submit the completed form.**

You can ask your provider to send it for you, but you are responsible for making sure the form is received to earn the reward.

There are two options available to submit your completed form:

1. **Fax** to (877) 568-2134
2. **Upload**: Login to your ActiveHealth Portal www.myactivehealth.com/stateofindiana
   Click on Rewards Icon and then Biometric Provider Form Upload link. Follow instructions to upload.

Check your form for these common errors:

- ☐ Make sure your screening date is in 2020.
- ☐ HbA1c is the only optional requirement.
- ☐ Make sure all other measurements are completed - **including waist circumference.**
- ☐ Make sure both you and your provider have signed the form.
- ☐ Make sure all information is legible.

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SECTION 1 - TO BE COMPLETED BY THE PARTICIPANT – ALL FIELDS ARE REQUIRED
NO REWARD WILL BE PROVIDED FOR PARTIAL OR INCOMPLETE FORMS

Enter information as it appears on your health insurance card.

Participant First Name:

Participant Date of Birth (Month/Day/Year): / /

Participant Last Name:

Gender: Female Male

Participant Email:

Participant Zip Code:

Participant Phone Number: – –

Name of Indiana State Employee (leave blank if Participant is the Employee):

I authorize the release of my biometric results to Repucare and ActiveHealth Management in order to receive the reward and for the purposes of providing health programs to me.

Participant Signature: _____

SECTION 2 – RESULTS AND PROVIDER INFORMATION COMPLETED BY PROVIDER
Note: HbA1C is optional, all other measurements are required.

Date of Screening: / /

BIOMETRIC	MEASUREMENT	BIOMETRIC	MEASUREMENT
Check if fasting>8 hr Fasting results more accurate	☐	**LDL (mg/dL)**	
Total Cholesterol (mg/dL)		**Height (feet and inches)**	
HDL (mg/dL)		**Weight (pounds)**	
Triglycerides (mg/dL)		**Waist Circumference (inches) REQUIRED**	
Glucose (mg/dL)		**Blood Pressure Systolic (mmHg)**	
HbA1C (%Hgb)* OPTIONAL		**Blood Pressure Diastolic(mmHg)**	

Provider Signature: _____

Provider Name (please print):_____

NPI # : _____ Provider Phone:_____