

Physician Results Form Instructions

Enclosed is a physician result form that will allow your doctor to perform your biometric wellness screening. To use this screening option, laboratory results must be collected between **01/01/2015** and **10/31/2015**. You are responsible for ensuring your doctor faxes the form directly to Quest Diagnostics, complete with all screening values and signatures, by **10/31/2015**. Results received in any other format will not be accepted. If the form is received after the deadline, you will not receive the participation credit for the program.

Please follow these steps carefully:

- Schedule an appointment with your doctor by **10/31/2015**. If you have already had your annual preventive care visit, your doctor's office may charge an office visit copay. In addition, your doctor may apply a fee for completing the form. **You are responsible for paying any such co-pays and/or fees.**
- Contact your doctor's office prior to your appointment to confirm he/she is able to measure all required Risk factors. Please see below for the risk factors that are required for the program. Forms that do not include results for all factors will not be processed.
- You will need to fast for at least 9 to 12 hours prior to your appointment. Continue taking medication as directed and be sure to drink plenty of water.
- You must sign and date the Wellness Participant section of the Physician Result Form (on reverse) before providing the form to your doctor.
- Provide your doctor the "Physician Result Form" (on reverse). Your doctor must complete the "healthcare Provider Completes" section of the form, including signature, date, and UPIN/NPI. The UPIN/NPI is a unique number that identifies your doctor's office; your doctor will know this number.
- **Your doctor must fax the completed form to Quest Diagnostics at 855-794-1391. You are responsible for ensuring your doctor returns this form by 10/31/2015.**
- If your form is complete with the required risk factors you will receive your results online within 10 days and a paper report in the mail within 3 weeks of submitting the form. If you have not received your results within the time frame described above please contact the Blueprint for Wellness Customer Support Center at 855-623-9355.



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Physician Results Form

Completed Form must be faxed to 855-794-1391.

Participant's Program Information																			
Company Name					BlueICR					Contract Name					Blue ICR Contract				
Participant Complete										<i>Complete this section before you visit your healthcare provider.</i>									
Last Name					First Name					Middle Initial									
Email Address							Gender			<input type="checkbox"/> Female <input type="checkbox"/> Male									
Unique ID					Date Of Birth					Phone Number									
Fasting >9 Hours		<input type="checkbox"/> Yes <input type="checkbox"/> No		Address															
City					State					Zip Code									
Participant Signature							Date												
Must be completed by Healthcare Provider										<i>The information on this form will be kept confidential.</i>									
<i>All fields on this form must be completed in their entirety, and the form returned by the designated</i>																			
Date Test(s) Performed																			
Testing and Measurements Must be Completed					01/01/2015 — 10/31/2015														
BIOMETRICS		Height (feet)			Height (inches)			Weight (lbs)			Waist (inches)								
Hip (inches)		Pulse			Systolic BP			Diastolic BP											
CLINICAL		Glucose (mg/dL)			Trigs (mg/dL)			HDL			Total Chol			LDL					
HgbA1c (%Hgb)		GGT (%Hgb)			Nicotine			<input type="checkbox"/> Nicotine User <input type="checkbox"/> Nicotine-Free											
Healthcare Provider Name (printed)							UPIN/NPI												
Healthcare Provider Signature							Today's Date												