Primary Care Provider Form

INSTRUCTIONS for Active Employees and Retirees (OGB Blue Cross subscribers/ policyholders)

If you were not able to receive a Catapult Health Preventive Checkup this year, you may have your Primary Care Provider report lab and biometric values to receive credit toward the Office of Group Benefits wellness incentive being offered. All information requested below must be completed in order for credit to be awarded. Once complete, you must return your completed forms to Catapult Health by 5:00 pm on August 31, 2018. Please follow the instructions at the bottom of this page. **This is your responsibility, not your provider's.** If you are pregnant, please refer to the Expectant Mother Form.

PATIENT AUTHORIZATION AND RELEASE

With the understanding that my personal health information will only be shared as permitted and protected by law, I agree to the release of the information requested below from my Primary Care Provider to Catapult Health in order to complete requirements for my Company's wellness incentive. Catapult Health will securely store and may also disclose this medical information to me, to my physician(s), to my health plan, or a third party entity designated by my current or any future health plan or employer for use in health and disease management programs. I understand this information may be used to identify my health risks, to provide education regarding how to address my identified risks, and to possibly contact me to promote participation in health and disease management programs. You will continue to have health coverage if you do not complete this form, however you may not receive credit for participating in the wellness program. You may revoke this authorization by writing to the address listed below; however, revocation will not affect any action taken before the revocation was received. This authorization will expire 6 months from the date of your signature.

PLEASE PRINT CLEARLY. If illegible, your information will not be recorded.

PATIENT'S NAME: _____ (First M.I. Last) **DATE:** _____ (Mo / Day / Year) **DATE OF BIRTH:** _____ (Mo / Day / Year)

PATIENT'S SIGNATURE: _____ **PHONE NUMBER:** ( ) -

PATIENT'S E-MAIL: _____ **BCBS LA Member ID:** _____

ADDRESS: _____ (Street or PO Box / City / State / Zip)

PROVIDER INSTRUCTIONS

Office of Group Benefits has partnered with Catapult Health to provide worksite wellness initiatives. Lab tests completed between 10/1/17 and 8/31/18 may be used to fulfill wellness incentive requirements. Please complete the information below and return this form to your patient. *Please order an HbA1c test to be completed on the same day as all other labs for patients with an abnormal glucose value or who have a history of prediabetes or diabetes.

Date of Tests		**Did patient fast?**	☐ YES ☐ NO
Total Cholesterol	mg/dL	**HDL Cholesterol**	mg/dL
Triglycerides	mg/dL	**LDL Cholesterol**	mg/dL
Glucose	mg/dL	**A1C ***	%
Height	feet inches	**Weight**	lbs.
Abdominal Circumference	inches	**Blood Pressure**	/
Gender	☐ FEMALE ☐ MALE		

Provider's Name (Please Print) _____ **Provider's Signature** _____

This completed form must be received by Catapult Health by 5:00 pm on August 31, 2018

VIA FAX: 877-885-9904 **VIA MAIL:** Catapult Health - PCP Form, 8144 Walnut Hill, Suite 1120, Dallas, TX 75231