



MA Primary Care Provider (PCP) Form - Biometric Screening

FOTH COMPANIES is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance.

The following information is needed to meet the requirements of participation in the screening:

Date of Biometric Results: _____

Participant Information and Biometrics (to be completed by PCP)

Name	
Date of Birth	
Social Security Number	Last 4 digits:
Best Contact Number	
Height	
Weight	
Blood Pressure	
Inches around waist at belly button to nearest 1/4"	
Participant uses nicotine products (Yes or No)	

Results from 2020 Blood Tests (to be completed by PCP - provide result for ALL tests listed)

Total Cholesterol	
LDL Cholesterol	
HDL Cholesterol	
Chol/HDL Ratio	
Triglycerides	
Glucose	

PRIMARY CARE PROVIDER (PCP) - contact Healics, Inc. at the number listed below if you have any questions regarding the blood test requirements.

PCP Name (Printed)

PCP Signature and Date

PARTICIPANT: Fax this form to 414-375-1639 **OR**

Mail this form to:
Healics, Inc., ATTN: HRA Processing Dept
8919 W. Heather Avenue, Milwaukee, WI 53224

Contact Healics with questions at 414-375-1600 or 800-432-5427