Biometric Screening Documentation Form

BlueCross BlueShield Kansas

Please **print** all information requested below.

Section 1 – Employee Information

First Name _____ MI _____ Gender ☐ Male ☐ Female _____/_____/_____ Date of Birth

Last Name _____ Suffix _____ Blue Cross and Blue Shield of Kansas Member ID Number

Section 2 – Employee Instructions

To receive credit for completion of biometric screening, please give this form to your medical professional/provider for completion. You or your provider will then mail to Blue Cross and Blue Shield of Kansas. Testing must be completed between [DATE] and [DATE].

Test results are to be provided directly to Blue Cross and Blue Shield of Kansas and your signature below is required for that purpose. Test results are NOT to be sent to your employer.

I hereby authorize the sharing of the listed clinical information with Blue Cross and Blue Shield of Kansas Disease Management and Wellness program staff for the purposes of documenting biometric values and trends within the BeWell program. These results will not be used in any way to determine insurance coverage or benefits.

Your signature required _____ _____/_____/_____

Employee Signature Date Signed

Section 3 – Medical Professional/Provider Use Only

Please record results and date of testing for each of the following (those in **bold** are required):

Height _____	_____/_____/_____	**A1c (if FBS > 126)** _____	_____/_____/_____
Weight _____	_____/_____/_____	Fasting Lipid Panel:	
Waist circumference _____	_____/_____/_____	Total cholesterol _____	_____/_____/_____
BMI _____	_____/_____/_____	HDL _____	_____/_____/_____
Blood pressure _____/_____	_____/_____/_____	LDL _____	_____/_____/_____
Fasting blood sugar _____	_____/_____/_____	Triglycerides _____	_____/_____/_____

Was patient fasting at least 8 hours prior to testing? ☐ Yes ☐ No Pregnant? ☐ Yes ☐ No ☐ N/A

Did you review these results and provide counseling? ☐ Yes ☐ No

Your signature required _____ _____/_____/_____

Medical Professional/Provider Signature Date Signed

_____

Medical Professional/Provider Printed Name

_____ (_____) _____-_____

Health Care Practice Name Phone Number

When completed and signed, mail this form to:

Blue Cross and Blue Shield of Kansas
Disease Management Department, Mailstop 466D4
1133 SW Topeka Blvd.
Topeka, KS 66629-0001