Continuous Health Improvement

Alternative Biometric Qualifications Form

All Fields are required unless noted.

access:health

Please have your Primary Care Physician/Medical Home complete this form and fax to Access Health within 3 months of your last physical. If not received before the end of the 1st month of enrollment in the program, you will not receive the incentives for participating in the program.

Members: Complete Section 1.

Physician: Complete Sections 2 and 3 of this form and submit it to Access Health by either fax (231-728-5160) or mail (1200 Ransom Street, Muskegon, MI 49442).

Due Date: This form must be completed and returned to Access Health by _____

Section 1: Member Information (to be completed by the member)		
Last name	First name	Middle initial
Last four digits of social security number XXX-XX-___ ___ ___ ___	Birth Date / /	Effective date / /
Member Signature		Date / /

Section 2: Provider Information (to be completed by the provider)					
Health Indicator	**Result**	**Date of test**	**Health Indicator**	**Result**	**Date of test**
Height		/ /	Total Cholesterol		/ /
Weight		/ /	LDL Cholesterol		/ /
BMI		/ /	HDL Cholesterol		/ /
Waist Circumference		/ /	Triglycerides		/ /
Blood Pressure		/ /	HbA1c		/ /
Tobacco User[1]	☐ Yes ☐ No	/ /	Form of nicotine ☐ Cigarettes ☐ Chew ☐ Nicotine gum/patch/lozenges ☐ Pipe ☐ E-cigarette ☐ Cigar		

Section 3: Physician Approval		
I certify that the information is complete and accurate. I agree to keep a copy of this form in the patient's chart for follow-up and Access Health audit.		
Tax I.D.	Provider Group (as it appears on your check)	Phone Number ( )
Billing physician name		NPI Number
Physician Signature		Date / /

[1] Any type of tobacco use