

# State of Rhode Island Health Rewards Program

## Biometric Screening Physician Form



**To receive incentive co-share credit this form must be completed by your primary care physician and returned to UnitedHealthcare by February 20, 2009.**

Employee Information (to be completed by employee)

Name (please print) \_\_\_\_\_

UHC Subscriber ID (on UHC card) OR SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_

Preventive Screening Verification (to be completed by physician)

\_\_\_\_\_ Blood Pressure Diastolic \_\_\_\_\_ Systolic \_\_\_\_\_  
(date)

\_\_\_\_\_ Body Mass Index (BMI) Height \_\_\_\_\_ ft \_\_\_\_\_ in Weight \_\_\_\_\_ lbs  
(date) BMI \_\_\_\_\_

\_\_\_\_\_ Body Fat \_\_\_\_\_ %  
(date)

I certify that the patient named above has received the above biometric screenings at my office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Physician \_\_\_\_\_  
(please print)

Physician address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician telephone: \_\_\_\_\_

\* In accordance with HIPAA, no personal health information will be shared with the State of Rhode Island.

Return completed forms to:

Linda Lynch  
UnitedHealthcare  
475 Kilvert Street  
Warwick, RI 02886

Or drop off at any onsite health fair  
January 1 – February 20, 2009

