



PHYSICIAN FAX PROGRAM INSTRUCTIONS

1. Schedule an appointment with your personal physician to receive your annual preventative screening examination.
2. Complete Section 1 of the enclosed Physician Fax form.
3. Take this Physician Fax form to your physical examination and have your physician complete Sections 2 the form. A licensed Medical Professional's signature is required.
4. Make a copy of the Physician Fax form for your records.
5. Once a Physician Fax form is completed, the form should be faxed to Summit Health at: **248-416-1197** or email to BSCAfaxes@summithealth.com. Forms can be mailed to Summit Health as the address below: **It is not necessary to mail and fax the completed form.**

**Summit Health Inc.
Data Integrity Group
27175 Haggerty Rd
Novi, Michigan 48377**

6. Do not fax or mail medical claims or other information or documents with this form. Any extra documents you fax or mail cannot be returned and will be destroyed.
7. Whether received by fax or mail, all first submission forms must be received by the date determined by employer in order to receive credit for completion of the Physician Fax Screening program.

If you have questions contact Summit Health toll free at 1-888-240-0963



County of San Bernardino
E0187572

Health Care Provider Biometric Screening Form

INSTRUCTIONS:

- PARTICIPANT - complete section 1
HEALTH CARE PROVIDER - complete section 2

Please fax completed form to Summit Health at (248) 416-1197 or email to BSCAfaxes@summithealth.com

SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed

Participant's Date of Birth (MM/DD/YYYY), Gender, Unique ID#, Participant's First Name, MI, Participant's Last Name, Address, Unit/Apt, City, State, Zip Code, Email Address, Phone Number, Are you: Employee, Spouse, Dependent

Please read the following disclosure statement. I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible).

Participant's Signature: _____ Date: (Month) (Day) (Year)

PATIENTS: Biometric Screening must be completed by (04/30/2016) to receive completion credit or incentive (if applicable). This form must also be completed in its entirety, accurately and legible in order to be deemed complete.

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - For physician or office staff use only below this line

FOR HEALTH CARE PROVIDER: County of San Bernardino is offering a voluntary wellness program to encourage participants to understand their health risk.

Blood Panel, Fasting Status, Blood Pressure, Body Composition, Pulse, Tobacco Use, For Females Only

I certify the listed biometric values are correct

Facility Name: _____

Phone Number: _____

Date of Service/Test: _____

Health Care Provider's Name: _____

Physician's Signature: _____

Date: _____

Please fax completed form to Summit Health at

(248) 416-1197 or email to

BSCAfaxes@summithealth.com by Deadline 04/30/2016

Date Faxed: _____

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid