RETURN COMPLETED FORM TO ALLEGEANT
mail: Allegeant, LLC, 1954 Greenspring Dr, Suite 640, Timonium, MD 21093
fax: 410-308-0865, or e-mail: adminsupport@allegeant.net
If you have any questions please call 800-748-8641

Allegeant
Employee Benefit Solutions

PHYSICIAN FORM

USE OF THIS FORM IS MANDATORY: NO SUBSTITUTIONS WILL BE ACCEPTED.

NOTE TO PROVIDER: Allegeant, LLC is a business associate of the employer-sponsored health plan in which the patient signing this form is enrolled and performs certain wellness program and other services for that plan. In performing those services, Allegeant is bound by and complies with applicable health information privacy and security requirements that apply under federal and state law, including the HIPAA privacy and security regulations and has signed a business associate agreement with the plan sponsor. Therefore, no HIPAA authorization form is required for you to release the requested information to Allegeant, in its capacity as a business associate of the patient's health plan. All personal health information provided on this form will be safeguarded against improper access, use and disclosure as required by HIPAA and other applicable law.

This section should be completed by PATIENT before providing the form to the health care provider:
Please provide the following information relating to my health status. By signing this form, I authorize you to provide this data to Allegeant, LLC.

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Patient Address: _____

Name of Company Employee Works For: Gray & Son, Inc.

Patient Signature: _____ Date: _____

This section to be completed by PHYSICIAN/HEALTH CARE PROVIDER:

Date of Office Visit: ____/____/____

*If pregnant, please use pre-pregnancy weight & waist.

Height: _____ ft. _____ in. Weight: _____ lbs.

Waist: _____ in. Hip: _____ in.

Blood Pressure: _____/_____

LDL: _____ HDL: _____

Total Cholesterol: _____

Triglycerides: _____

Fasting Blood Glucose Level: _____
-OR-
A1C (if applicable): _____

Is the patient on any of the following management medications?

Cholesterol ☐ YES ☐ NO
Blood Pressure ☐ YES ☐ NO
Blood Sugar ☐ YES ☐ NO

Nicotine Metabolite Test: _____
(If required by employer)

Has the participant used any form of tobacco in the past six months? ☐ YES ☐ NO

Is the participant up to date on the following USPFTF Preventative Health Care Recommendations?

Preventative Health Visit: ☐ YES Date: _____ ☐ NO ☐ N/A ☐ UNK

Breast Cancer Screening: ☐ YES Date: _____ ☐ NO ☐ N/A ☐ UNK

Cervical Cancer Screening: ☐ YES Date: _____ ☐ NO ☐ N/A ☐ UNK

Colorectal Cancer Screening: ☐ YES Date: _____ ☐ NO ☐ N/A ☐ UNK

Complete this section ONLY if you are the Primary Care Provider:

Is the participant being treated for any of the following chronic conditions?

☐ Diabetes ☐ CAD ☐ COPD/Emphysema
☐ Arthritis ☐ Cancer

Other: _____

Chronic Conditions:
Adherence demonstrated to recommended guidelines/ interventions?

☐ YES ☐ NO ☐ N/A

Based on this participant's current health and risk status, I recommend that he/she schedule their next Preventative Health Visit:

_____ Quarter _____ Year

Physician/Health Care Provider Name: _____ Phone Number: _____

Physician/Health Care Provider Signature: _____ Date: _____

Physician/Health Care Provider Address: _____ Tax ID#: _____