



# Medical results form

Dear Provider:

Your patient is voluntarily participating in an incentive program through his/her employer. The incentive program encourages participants to make wellness part of their daily routine. Your patient has indicated that he/she recently had/or will have the following measures taken. **There are deadlines for participants to submit results.** If we can be of assistance or answer any questions, please call 866-415-7138.

**This form may be faxed, emailed, or mailed directly to:**

Geisinger Health & Wellness  
 M.C. 25-67  
 Danville, PA 17822-5002

Phone: 866-415-7138  
 Fax: (570) 214-7742  
 Email: ghp\_wellness\_staff@thehealthplan.com

SECTION 1		PARTICIPANT INFORMATION <i>(to be completed by participant)</i>		EMPLOYER:	St. Luke's University Health Network
Participant Name (Last, First, Middle Initial)			Participant Date of Birth	Member ID # (If applicable):	
Participant Home Address			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Participant Phone #	
<p>The information that I have supplied to my physician is complete and accurate. If applicable, I agree to follow my physician's recommendations. I am solely responsible for seeking medical attention in follow-up for results that are outside normal ranges and may require investigation and treatment with my physician.</p> <p>I authorize GHP to release to my employer, the fact that I participated in the screenings indicated for the purposes of my employer's wellness program.</p>					
Participant Signature:				Date:	

SECTION 2		RESULTS SECTION <i>(to be completed by the physician's office)</i>			
Current Tobacco Use:			Current Diagnosed Conditions:		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease		
Valid results must be between 4.1.18 – 8.31.18					
Date of Results:	/ /		Date of Results:	/ /	
Height:			LDL:		
Weight:			Tot Chol/HDL Ratio:		
Blood Pressure:			HbA1c:		

SECTION 3		SIGNATURES		
Provider Name (Please Print):		NPI#:	Phone ( )	
Provider Signature:			Date: / /	
Provider Address:				