ahealthyme℠

Biometric Screening Form

Williams College

SECTION I: ***TO BE COMPLETED BY PARTICIPANT*** **(PLEASE PRINT)**

Name: _____ BCBSMA ID #: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ DOB: _____

Email: _____

Signature: _____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOUR PROVIDER***

Screening Date: _____ Fasting (please circle): YES / NO

Height: _____feet _____inches Weight: _____pounds Waist Circumference: _____inches

Total Cholesterol: _____mg/dl HDL: _____ Ratio Total/HDL: _____

Glucose Level: _____ mg/dl Blood Pressure: _____ / _____ mm/Hg

Body Fat %:_____ Body Mass Index (BMI):_____

Provider's Signature: _____

Provider's Name (please print): _____

Provider's Address: _____

_____

Return this form by: e-mail (offsiteforms@interactivehealthinc.com), fax (410-356-6205) or mail (Interactive Health, Attn: Alternative Means, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117).

PLEASE PICK ONE METHOD FOR SUBMITTING YOUR RESULTS by 10/31/2020

IT IS THE PARTICIPANT'S RESPONSIBILITY TO RETURN THIS FORM.

Notice of Use and Disclosure of Information. Health Solutions Services, Inc. ("HSS"), a subsidiary of Interactive Health Solutions, Inc., will share the fact of your participation and your actual results from this voluntary wellness screening with Blue Cross Blue Shield of Massachusetts ("BCBSMA"). HSS discloses this information to receive payment for the screening services it provides. BCBSMA may use this information to identify opportunities to provide education regarding certain health risks and may contact you to promote participation in health and disease management programs.

MASSACHUSETTS