PHYSICIAN FAX FORM

ALL INFORMATION IS REQUIRED TO PROCESS YOUR PHYSICIAN FAX FORM.
INCOMPLETE OR ILLEGIBLE FORMS WILL DELAY DATA ENTRY.

By submitting this form I am requesting my physician to report results to HealthCare Strategies, Inc. (HCS) to be included as part of an employer sponsored wellness program.

Participant Instructions

1. Print this form and ask your physician to complete the form in its entirety.
2. This completed form must be faxed to HCS at **(410) 423-9430**.
3. Review this form for completeness before submission to HCS. Incomplete forms will cause a delay in data entry and processing.

Physician Instructions

1. We are encouraging employees and plan members to take an active role in their health by offering a screening and wellness program.
2. Complete Section 2 and Section 3 of this form in their entirety.
3. Sign and date Section 3.
4. Return to patient or fax completed form to HCS at **(410) 423-9430**.

Important: Save a copy of this confirmation form along with the proof of fax (if available). If HCS does not successfully receive your faxed form(s), you will be required to provide a copy.

PART 1 - PLAN MEMBER INFORMATION

First Name:

Last Name:

DOB:

Gender: ☐ Male ☐ Female

Phone:

Email:

PART 2 – RESULTS

Fasting: ☐ Yes ☐ No

Blood Pressure

Systolic	Diastolic

Height: _____FT _____IN **Weight:**_____LBS

☐ Glucose ☐ A1C (mg/dL)	HDL Cholesterol (mg/dL)	Total Cholesterol (md/dL)	LDL Cholesterol (mg/dL)	Triglycerides (mg/dL)

Date of Exam: ____ ____ ____
MM DD YYYY

SECTION 3 – PHYSCIAN INFORMATION (All Information is Required)

By providing Physician Information below, I certify that the Results provided in Section 2 belong to the Patient identified in Section 1 of this form.

_____ _____ _____
Physician Signature **Physician Phone Number** **Date**

_____ _____
Physician Name (Please Print) **UPIN / NPI**