



Biometrics Form

All fields on this form are required. Your form will not be processed if information is missing.
Please print clearly.

Participant Information

Participant Signature: _____
Participant Printed Name: _____
Participant Date of Birth (mm/dd/yyyy): _____
HealthPartners member ID: _____
Contact information: Phone number: _____ E-mail address: _____

Today's Date: _____ (Lab results must be from 3/1/2015 – 2/28/2016 to be accepted)

Screening Results (to be completed by the provider)

Blood Pressure: Systolic _____ Diastolic _____	Collection Date: _____
Blood Glucose: _____ <input type="checkbox"/> Fasting	<input type="checkbox"/> Non-Fasting
Cholesterol: Total _____ <input type="checkbox"/> Fasting	<input type="checkbox"/> Non-Fasting
HDL _____	Collection Date: _____ (if different than above)
Body Mass Index: _____	
Height: _____	Collection Date: _____ (if different than above)
Weight: _____	

Provider Information

Provider Signature: _____	Date: _____
Provider Printed Name: _____	This form must be faxed by the physician office to HealthPartners at 952-883-6767 by 2/28/2016
Provider Title: _____	

By signing this, you're authorizing HealthPartners to inform your employer, the City of Saint Paul, that you have completed the biometric screening, which is one of the components required to qualify for the incentive in 2017.

Signature: _____ Date: _____

HealthPartners Internal Office Use Only

City of Saint Paul

Date Received: _____

Date Processed: _____