DIABETES MANAGEMENT

FORM INSTRUCTIONS	Make a copy of the form for your records and return by:
The form is not valid unless completely filled in and signed by the member and the provider.	Mail: HealthSCOPE Benefits 27 Corporate Hill Drive, Little Rock, AR 72205
Sections A, and C should be completed by YOU.	Fax: 800-458-0701
Section B must be completed by a Clinician.	Email: diabetes@healthscopebenefits.com

SECTION A Member Information

First Name: _____ Last Name: _____ MI: _____ Gender: M / F

Date of Birth: _____/_____/_____ Employer: _____ Insurance ID: _____

Circle One: Employee/Spouse/Child/Retiree/Domestic Partner/Other Dependent

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ____-____-_____ Cell: ____-____-_____ Email: _____

SECTION B Biometric Assessment (MUST be completed by a CLINICIAN)

I am currently Pregnant: ☐ (Check if YES) Baby Due Date: ____/____/_____

Total Cholesterol	
LDL (Bad) Cholesterol	
HDL (Good) Cholesterol	
Triglyceride Level	
HgbA1C	
Fast Glucose	
Blood Pressure	
Height (Inches)	
Weight (lbs)	
BMI	

Known Chronic Illnesses (check all that apply): ( ) Diabetes ( ) Asthma ( ) Heart Disease
( ) Hypertension ( ) Depression ( ) Hyperlipidemia ( ) ADHD Other Conditions: _____

I, the undersigned, hereby certify that I am the named member's healthcare provider and I certify that I have examined the named member sufficiently to answer the above questions. Further, I certify that the above answers are true and accurate statements regarding the named member's condition.

Healthcare Provider Signature: _____

Healthcare Provider Printed Name: _____

SECTION C Signature (to be completed by YOU)

By signing, I authorize the disclose of my health screening results to HealthSCOPE Benefits. All information released to HealthSCOPE Benefits will be protected in accordance with any applicable law. I understand that information contained on this form will not be shared with my employer.

Signature: _____ Date: _____