

## 2019 Provider Qualification Form

**Please return completed form to Ulliance by Septmeber 6, 2019.  
Incomplete forms will not be accepted.**

**Participant Instructions:** Complete, in full, this part of the form and take it to your health care provider to complete. Biometric screening results must be from **no earlier** than January 1, 2019. **Obtain a copy of this completed form for your records and to use when completing the online Health Risk Assessment (HRA). Submit this form to Ulliance by Fax: 248-680-2103 or Email: chasselbring@ulliance.com by September 6, 2019.**

Employer: **Wayne State University**

Last Name	First Name
Banner or Access ID	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Phone Number	Date of Birth

By signing below, I consent to the participation in the Wellness Warriors program, associated screenings, and to the release of my medical information to Ulliance. I understand that my participation is voluntary and my employer will not receive my results.

Signature	E-Mail Address
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**Provider Instructions:** Please make sure that all appropriate sections below are completed in full.

- If using results from a previous physical, they must be from no earlier than January 1, 2019
- Sign and return the form by 09/06/19 to: Fax: 248-628-2103 or Email: chasselbring@ulliance.com**

Date of Exam:	Fasting Status: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulliance Use Only	
BIOMETRIC SCREENING TARGETS	BIOMETRIC SCREENING VALUES		
<b>Tobacco Use</b> Target: Never used or quit > 6 months	Tobacco Use <input type="checkbox"/> No, non-user <input type="checkbox"/> Yes, user	<input type="checkbox"/> Risk	<input type="checkbox"/> No Risk
<b>Body Mass Index</b> Target: BMI ≤25	Height _____ ft _____ in Weight _____ lbs BMI _____ Waist Circumference _____ in	<input type="checkbox"/> Risk	<input type="checkbox"/> No Risk
<b>Blood Pressure</b> Target: <120/80; both numbers	BP _____ / _____ Pulse _____	<input type="checkbox"/> Risk	<input type="checkbox"/> No Risk
<b>Total Cholesterol</b> Target: <200	Total Cholesterol _____ LDL _____ TRG _____ HDL _____ TC/HDL Ratio _____	<input type="checkbox"/> Risk	<input type="checkbox"/> No Risk
<b>Blood Sugar (Glucose)</b> Target Fasting: <100 Target Non-fasting: ≤139	Blood Sugar _____	<input type="checkbox"/> Risk	<input type="checkbox"/> No Risk
<b>Other/Comments:</b>			<b># of Health Targets Met:</b>

**Provider Signature:** By signing below, I verify the information above is complete and accurate.

Provider Printed Name	Tax ID
Provider Signature	Provider Phone Number
Date	

**Return to Ulliance:**

**Email:** chasselbring@ulliance.com    **Fax:** 248-680-2103    **Mail:** 900 Tower Dr., Suite 600, Troy, MI 48098