Laitram Preferred Premium Program
2024 Annual Physical with Labs/Biometric Screening Form

NOTICE TO MEMBER

Please fill out the top portion of this form and take it to your medical provider when you complete your biometric health screening. This activity **must** occur between January 1, 2024 and October 15, 2024 to count towards the Preferred Premium Program activities. If new to plan, you have 120 days from effective date of coverage on the health plan to complete activities. **Once completed by your provider, it is YOUR responsibility to return this form to Marathon Health at the contact information below.** BY COMPLETING THIS FORM AND SUBMITTING IT TO MARATHON HEALTH, YOU CONSENT TO THE DISCLOSURE BY MARATHON HEALTH TO LAITRAM THAT YOU HAVE COMPLETED THE BIOMETRIC SCREENING. We will not disclose the specific results reported on this form and will use the results only to support the health services that we provide to you. You may revoke your consent to this disclosure at any time by sending us a notice in writing. Your revocation will not apply to information already disclosed by Marathon Health pursuant to this form.

TODAY'S DATE

PATIENT NAME (Please Print Clearly) | DATE OF BIRTH | EMPLOYEE ID

NOTICE TO PROVIDER

Your patient has an opportunity to complete a biometric screening and/or annual physical as a part of a wellness incentive program. Please review the components to be included in the screening. When the screening is complete, please fill out this form, sign and date it and return it to the patient. Please fill out this form completely.

QUALIFYING PROGRAM ACTIVITY	DATE OF EXAM	PROVIDER INITIALS
ANNUAL PHYSICAL		
ANNUAL HEALTH SCREENING CRITERIA	**DATE TEST ADMINISTERED**	**RESULTS**
BODY MASS INDEX (BMI)		Height_____in. / Weight _____lbs BMI _____ . _____
WAIST CIRCUMFERENCE		Value: _____in.
BLOOD PRESSURE		Value: _____ / _____ mmHg
TOTAL CHOLESTEROL		Value: _____mg/ dL
HDL CHOLESTEROL		Value: _____mg/dL
TOTAL CHOLESTEROL TO HDL RATIO		Value: _____._____
HEMOGLOBIN A1C OR GLUCOSE		Value: _____% or _____ mg/dL

PROVIDER SIGNATURE

PLEASE PRINT (OR PROVIDER STAMP)

PROVIDER PHONE NUMBER

DEADLINES:
Forms due to Marathon Health no later than October 15, 2024.
NEW to plan: Submit within 120 days from effective date of coverage on the health plan.

FAX OR EMAIL YOUR COMPLETED FORM TO THE ADDRESSES OR FAX NUMBER BELOW.

Marathon Health
F: 802.419.9688
E: wellness@marathon-health.com

Marathon Health