Instructions
Health Provider Screening Form

The Health Provider Screening Form is used to collect screening data performed by your Healthcare Provider, as an alternative to being screened by HMI. To ensure your form is processed in a timely manner, please be sure to follow all instructions as provided.

You OR your Healthcare Provider may return your completed form on your behalf, however HMI recommends you follow up with your provider to ensure the form is complete and returned prior to your program's deadline. Incomplete forms will not be processed. You will be notified if an incomplete form is submitted along with directions on what is incomplete.

PARTICIPANT INSTRUCTIONS

Exam must have occurred on or after 01/01/2019:

- Complete Sections 1 & 3 *(on pg. 2).*
- Have your Healthcare Provider complete Section 2 *(on pg. 2).*
- ALL information in Section 2 MUST be completed by your Healthcare Provider.
- Return completed form to HMI via fax or mail before the deadline.

Return Options

- **Fax #**: 312-858-6330 • ATTN: HP Department
- **Mail**: HMI HP Department • 2604 E. Dempster St; Suite 301; Park Ridge IL, 60068

Note: *HMI is not responsible for any costs associated with your screening/physical.*

PARTICIPANT INSTRUCTIONS

Go to www.myhmihealth.com

Returning Users

- If you have already created an online account for a previous wellness screening, please login with the same username and password you created.

New Users

- Please click "Register Account" and complete all required fields. Your site code is: **L773**

Complete the REQUIRED Health Power Assessment.

NOTE

- Forms are processed within 5 business days of receipt.
- Incomplete forms will be rejected. You will be notified via email of the rejection along with what is needed to complete the form correctly.

HEALTHCARE PROVIDER INSTRUCTIONS

1. Complete all information requested in Section 2 *(on pg. 2)*. All fields are required in order to process the form. **The form will be REJECTED by HMI and returned to the participant if information is not completed.**
2. Sign and complete office information or use office stamp.
3. Return completed form to HMI on or before the deadline noted on this form.

*Contact HMI at **847-635-6580** if you have any questions or issues with completing or returning this form.*

Health Provider Form MUST be returned by: **11/27/19**

LOYOLA UNIVERSITY

HEALTH PROVIDER SCREENING FORM

THIS FORM MUST BE COMPLETED AND RETURNED BY 11/27/19

SECTION 1: PARTICIPANT INFORMATION

Last Name

First Name

Mailing Address | Apt #

City | ST | Zip

Email Address

Provide the LAST 4 digits of your Social Security # | Birth Date | Employee | Spouse/ Domestic Partner | Male | Female

Phone #

If Spouse/Partner, Record Employee Name Below:

____

SECTION 2: BIOMETRIC SCREENING RESULTS (to be completed by your Health Provider)

ALL FIELDS ARE REQUIRED
Your form will be rejected if all fields are not completed and you will be notified by email.

Date of Exam or Lab Testing

EXAM **MUST** HAVE OCCURRED **ON OR AFTER 01/2018**

Hours Fasted

Height — Feet . Inches .

Weight — Pounds .

Blood Pressure — Systolic / Diastolic

Glucose — mg/dL

Total Cholesterol — mg/dL

HDL Cholesterol — mg/dL

TC/HDL Ratio — .

LDL Cholesterol — mg/dL

Triglycerides — mg/dL

____
Healthcare Provider's Signature (REQUIRED)

____
Healthcare Provider's Name (PLEASE PRINT)

____
Office Street Address, City, State, Zip

(__________)______________________________
Office Area Code and Phone Number

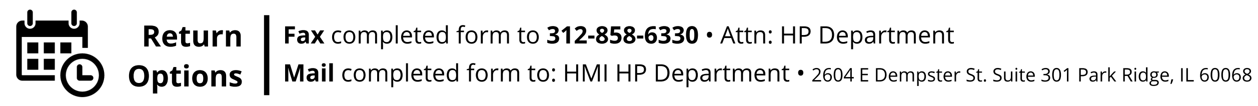
Office Address Information Stamp (if available)

SECTION 3: PARTICIPANT SIGNATURE (required for processing)

By signing, you indicate your understanding and agreement that HMI may use your test, screening and assessment results, as well as any other health or personal information which you provide. You understand that participation in this program, and this authorization, is voluntary. HMI Notice of Privacy Practices has been made available to you in connection with this program. A current copy of HMI's Notice of Privacy Practices is available at www.myhmihealth.com. Your signature acknowledges receipt and acceptance of the privacy policy. All sections of this form must be completed in order to be processed. If you fail to return a complete form, you will not be eligible for incentives. By signing below, I give my Health Provider listed above permission to fax or mail this information to Health Maintenance Institute.

______________________________ ______________________________
Patient Signature REQUIRED **Date**

Please **FAX** or **MAIL** your completed Health Provider Screening Form by: **11/27/19**



Return Options

Fax completed form to **312-858-6330** • Attn: HP Department

Mail completed form to: HMI HP Department • 2604 E Dempster St. Suite 301 Park Ridge, IL 60068