Please take this form to your physician to be completed. Please mail this form and the required documentation to: Secure Health Plans, P.O. Box 4088, Macon, GA 31208 or fax to 478-314-2417 or email to Wellness@shpg.com.

(If using this form for Dental or Vision Incentive credit – complete the top portion only and attach a copy of the Explanation of Benefits (EOB) or a copy of the billing invoice from your appointment)

Patient Name: _____ Date:_____

Health Plan Policy Number:_____Date of Birth:_____

Physician Name: _____ Phone Number:_____

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The physician's office must complete each of the measurements below for the biometric screening.

- Lab work necessary for completion of HRA- (**must attach a copy of results**)
    1. Fasting Glucose
    2. Total Cholesterol
    3. HDL
    4. LDL
    5. Triglycerides
- Blood Pressure:_____
- Height:_____
- Weight:_____
- Body Fat Percentage:_____
- Waist Girth:_____