Primary Care Provider Form 2024

SUBMISSION DEADLINE 12/31/2024

To qualify for Wellness Rewards, you may choose to have your Primary Care Provider complete the screening. All information requested below must be completed for credit to be awarded. Once your physician completes this form, your results can be submitted as per the instructions below. Please keep a copy for your records. **The form is your responsibility, not your provider's, and it must be completed and received by December 31, 2024.**
This form must be submitted within 30 calendar days of the provider's signature. Note that it may take up to 60 days or more for the premium credit to process and it is not retroactive.

STEP 1: PATIENT AUTHORIZATION AND RELEASE

With the understanding that my personal health information will only be shared as permitted and protected by law, I agree to the release of the information requested below from my Primary Care Provider to Catapult Health to complete requirements for my Company's wellness incentive. Catapult Health will securely store and may also disclose this medical information to me, to my physician(s), to my health plan, or a third-party entity designated by my current or any future health plan or employer for use in health and disease management programs. I understand this information may be used to identify my health risks, to provide education regarding how to address my identified risks, and to possibly contact me to promote participation in health and disease management programs.

PLEASE PRINT CLEARLY | INCOMPLETE FORMS CANNOT BE PROCESSED | ** Indicates Field Required*

PATIENT'S NAME * _____ **PATIENT'S SIGNATURE *** _____
First M.I. Last

DATE * ____/____/____ **DATE OF BIRTH *** ____/____/____ **GENDER *** MALE FEMALE
Mo / Day / Year Mo / Day / Year (Circle One)

ADDRESS * _____
Street or PO Box City State Zip

PHONE NUMBER _____-_____-_____ **EMAIL** _____@_____

_____ ***(INITIALS)*** *I agree to receive text messages and/or email communication regarding the status of my form. I understand that I may text STOP to unsubscribe at any time from text messages regarding my PCP Form. Message frequencies may vary, and data rates may apply. For more information, please see Catapult Health's Terms of Use and Notice of Privacy Practices at www.catapulthealth.com*

STEP 2: PROVIDER INSTRUCTIONS

The Brink's Company has partnered with Catapult Health. Please complete the information below and return this form to your patient or use the directions below to email or fax to Catapult Health.

PROVIDER'S NAME *		**PROVIDER'S SIGNATURE ***	
DATE OF TESTS * *(01/01/24 – 12/31/24)*		**DID PATIENT FAST? *** PLEASE CHECK ONE OPTION	☐ YES ☐ NO
HEIGHT *	FEET INCHES	**WEIGHT ***	LBS.
ABDOMINAL CIRCUMFERENCE	INCHES	**BLOOD PRESSURE ***	/
TOTAL CHOLESTEROL *	MG/DL	**HDL CHOLESTEROL ***	MG/DL
LDL CHOLESTEROL *	MG/DL	**TRIGLYCERIDES ***	MG/DL
GLUCOSE *	MG/DL	**A1C** *(OPTIONAL)*	%

STEP 3:

Completed forms must be sent to Catapult Health for processing using one of the following methods. Please keep a copy for your records.

- Secure Email Submission using the website address: https://securecontact.me/support@catapulthealth.com
- Encrypted Fax Submission: 877-885-9904
- Questions? Please TEXT 855-509-1211 for Catapult Health Patient Support (Monday - Friday 8am-5pm (CT))