HealthAdvocate℠ | Albuquerque Public Schools Employee Wellness Promoting a Culture of Health

Physician Engagement Form

To be completed by Employee, Spouse/Domestic Partner

If you and your spouse/domestic partner are enrolled in the APS medical plan then each of you will complete this form.

(Please Print)

Last Name: _____ **First Name:** _____

Company: Albuquerque Public Schools **Zip Code:** 87125 **Employee ID#:** _____ (required)

Choose One: Employee ☐ Spouse ☐ Domestic Partner ☐

Last 4 SS#: _____ **DOB:** _____ _____ _____ **Gender:** Male ☐ Female ☐
(Month) (Day) (Year)

Email Address: _____ **Phone:** _____

If for spouse or domestic partner, please list employee's name: _____ I

authorize my healthcare provider to release the requested information to Health Advocate.

Signature: _____ **Date:** _____

Do not write below this line

To Be Completed by Provider's Office

Please check the box appropriate to the exam performed between October 1, 2016 - September 30, 2017.

☐ Annual Preventive Physical Exam

_____/_____/_____**DATE OF EXAM**

_____	_____	_____
Healthcare Provider/Verifier Signature	Office Telephone Number	Signature Date

Please fax this document to Health Advocate at 1.610.397.7891 or email it to biometricforms@healthadvocate.com.

IT IS PREFERRED THAT THE FORM BE FAXED OR EMAILED FROM A PHYSICIAN'S OFFICE, BUT NOT MANDATORY.

Exam date and type may be verified with physician's office

