

Health Action Notification Form

MEDICA®



Form required:

- Biometric screening performed in your clinic

Instructions:

- Complete all sections below
- Attach biometric (lab) results from your physician or provider
- Keep a copy of forms for your records
- Send all documentation to the address or fax number below

Member Information

Member's Last Name	First Name	Middle Initial	Date of Birth	
Member ID Number (on Medica ID card)		Member Group/Policy ID (on Medica ID card)		
Address – Number and Street		City	State	Zip Code
Signature			Date	

Biometric Screening Values
Lab results from provider are required

Date of Service ____ / ____ / ____

Total Cholesterol _____

Glucose _____

HDL _____ *LDL* _____

Triglycerides _____

Blood Pressure _____ / _____

Height (ft.) _____ (*in.*) _____

Weight (lbs.) _____

Send this form & lab results:

By mail:
My Health Rewards by Medica
401 Carlson Parkway, CP217
Minnetonka, MN 55305

Or by secure fax:
952-992-3595
Attn: My Health Rewards

Please allow 15 business days for your scorecard to update.