Jackson Healthcare Live Well Wellness Incentive Program

Alternative Means Authorization Form Instructions

Jackson Healthcare benefits-eligible associates are encouraged to participate in a wellness screening to gain important knowledge about their health status and to earn their incentive. The Alternative Means Screening Process allows those who are unable to, or choose not to, participate in a screening with Crossover Health, the option to have their outside provider complete their biometric screening and submit the results to the program.

The process is simple:

1. Ask your provider to complete and sign the attached "Authorization to Release Biometric Screening Information" form using exam and lab results from a visit between January 1, 2024 and December 31, 2024. Test results may not be available the same day, so plan accordingly. Completed forms must be received by Crossover Health by the program end date. Note, if you complete your Physical Exam at Jackson Healthcare's Health and Wellness Clinic you do not need to submit this form.
2. If you cannot visit your healthcare provider, but you have lab results from a screening between January 1, 2024 and December 31, 2024, you can fill out all required boxes on the Biometric Screening Form yourself. No medical provider signature is required on the form as long as you include a copy of your official laboratory results.
3. Review your form carefully before submitting. Crossover Health will only process forms that have been fully completed.
4. Submit this form to Crossover Health one of the following ways:
    - Start a message in the Crossover app and attach the form with a note stating what the form is for
    - Fax the form to the On-Campus Health & Wellness Clinic: (770) 764-0390
    - Bring a copy of the form to the On-Campus Health & Wellness Clinic

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BIOMETRIC SCREENING INFORMATION To participate in the Biometric Screening program, you and your medical healthcare provider must complete and sign this entire form. If any items are left blank or unsigned by your healthcare provider, this form will be considered incomplete. Note, provider signature is not required if you are completing and submitting this with an official lab report.

PARTICIPANT INFORMATION: PARTICIPANT MUST COMPLETE THE INFORMATION BELOW			
Associate ID:		**Full Name:**	
Date of Birth:		**Gender:**	☐ Male ☐ Female
Mailing Address:		**City, State, Zip Code:**	
Phone number:		**Work Email Address:**	

BIOMETRIC SCREENING: MEDICAL HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW UNLESS YOU ARE SUBMITTING AN OFFICIAL LAB REPORT PERFORMED PREVIOUSLY.				
Date of Service:	**Were these labs fasting?** This means s/he has NOT had anything to eat or drink other than water in the last 9-12 hours. *Note: Fasting is preferred, but not required.*			☐ Yes ☐ No
Height (inches):	Weight (pounds):	Waist Meas(inches):	Blood Pressure: /	Glucose:
HDL:	LDL:	Triglycerides:	Total Chol:	HgbA1c:
Medical Health Care Provider Name (Please Print):_____				
Medical Health Care Provider Signature*:_____ **Date:**_____ *Signature only required if results are transcribed by provider without supporting lab report attached.				
Facility Name:		**Telephone Number:**		
Participant Signature:_____ **Date:**_____				

On-Campus Health & Wellness Clinic
Jackson Healthcare, 2655 Northwinds Pkwy, Alpharetta, GA 30009
Clinic Phone Number: (678) 690-7852
Clinic Fax Number: (770) 764-0390