EVANGELICAL CHRISTIAN SCHOOL

Biometric Screening Provider Form
Screening Time Period: September 15, 2026 – July 31, 2027

Participant: Health Risk Assessment Questionnaire
You must complete an updated Health Risk Assessment Questionnaire located in the inHealth Wellbeing app or at https://myhealth.inhealth4change.com for biometric screening results to be submitted to earn wellness rewards.

Participant: All Information Below Is Required	
Participant Name:	Baptist Location:
Date of Birth:	Employee ID:
Phone Number:	Email Address:

***Biometric Screenings Must Be BestHealth-Approved**! If additional services are provided—such as medication refill, or evaluation of new or ongoing concerns—additional charges will apply.

Provider: Annual Wellness Visit (AWV)	
If participant completed an AWV between September 15, 2026 and July 31, 2027, use one of the following CPT code(s): 82947, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, ***ICD** Please note that if the AWV is completed at the same time as the biometric screening, this form is inclusive to the AWV and would not be billed separately with a 99401. ***The 99401 should be used in cases where the AWV has already been billed during this calendar year and the patient comes in for a biometric screening.***	**Record Date of AWV In Box if Completed:**

***Please use the correct ICD code for the corresponding procedure.**

Provider: Tobacco/Nicotine Status	
Does the participant currently use any tobacco, nicotine or e-cigarette products?	☐ **Yes** ☐ **No**

Provider: All Biometrics and Lab Results Fields Below Are Required			
Biometrics (current)		Lab Results (current or within last 180 days)	
Height (inches):		Fasting (Yes/No)?	
Weight (pounds):		Blood Glucose - ***OR***- A1C: CPT: 82962, 82947, 82948,83036, ***ICD**	
Waist (inches):		Total Cholesterol: CPT: 80061 ***ICD**	
BMI:		Triglycerides:	
Pulse:		HDL:	
Blood Pressure:		LDL:	
		Venipuncture CPT 36415 *ICD	

***Please use the correct ICD code for the corresponding procedure.**

The completed biometric screening form must be faxed by the Provider to BestHealth at 901-227-2377 no later than July 31, 2027. For questions call BestHealth at 901-227-2378 or email besthealth@bmhcc.org.

Provider Name (print)_____ Provider Signature_____

Date of Biometric Screening_____