OSU Primary Care Provider Form

Please have your Primary Care Provider complete the information below. All information requested below must be completed in order for credit to be awarded. Once complete, your PCP must return your completed forms to Catapult Health. Once your form is received, your premium credit for 2020 will be effective the following month. Please follow the instructions at the bottom of this page. **This is your responsibility, not your provider's.**

This must be completed to receive the incentive for participation in the Oklahoma State University checkups.

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 in order 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. If illegible, your information will not be recorded.

PATIENT'S NAME:_____ **DATE:**____/__/_____ **DATE OF BIRTH:** _____/__/_____
First M.I. Last Mo / Day / Year Mo / Day / Year

PATIENT'S SIGNATURE: _____ **PHONE NUMBER:** (_____) _____-_____

PATIENT'S E-MAIL: _____

ADDRESS: _____
Street or PO Box City State Zip

PROVIDER INSTRUCTIONS

Oklahoma State University has partnered with Catapult Health to provide worksite wellness initiatives. Lab tests completed within the last 60 days may be used to fulfill wellness incentive requirements. Please complete the information below and mail to Catapult Health using the information listed below.

Provider's Name		**Provider's Signature**	
Date of Tests		**Did patient fast?**	☐ YES ☐ NO
Total Cholesterol	mg/dL	**HDL Cholesterol**	mg/dL
Triglycerides	mg/dL	**LDL Cholesterol**	mg/dL
Glucose	mg/dL	**A1C** *(optional)*	%
Height	feet inches	**Weight**	lbs.
Abdominal Circumference	inches	**Blood Pressure**	/
Gender	☐ FEMALE ☐ MALE		

This completed form must be mailed by the PCP or by yourself to Catapult Health.

VIA MAIL: Catapult Health - PCP Form, 8144 Walnut Hill, Suite 1120, Dallas, TX 75231

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