West Virginia Public Employees Insurance Agency
Improve Your Score Premium Discount Program

CAUTION!

Using this form may result in additional costs to the policyholder including copayment, deductible and coinsurance! Free screenings are available through Pathways to Wellness and participating LabCorp sites. Go to www.peiapathways.com for details.

Worksite ID: 00109555

Instructions for Patient (PPB Insured)

1. Please complete the information below.
2. Submit sheet to Provider for completion
3. **Mail** the completed form to beBetter Health

Mail to:
beBetter Health, Inc.
Attn: Rob Tuell
6 Craddock Way
Poca, WV 25159

Last Name: ______________ First Name: ______________ Home County: __________

Mailing Address ______________________ City ______________ State ____ Zip ______

Work Phone (____) _____-______ Home Phone (_____) _____-______ Cell Phone (_____) _______-______

Date of Birth _____ /_____ /______ Age ______ Gender M F Email Address ______________

10 Digit Member ID# : 7700 __ __ __ __ __ __
(located on insurance card)

Last 4 digits of Primary Insured's SSN: ______________
Last 4 digits of Family Insured's SSN: ______________

Preferred Provider Benefit (PPB) members are encouraged to participate in the new Improve Your Score Premium Discount Program. As a health service provider, please complete this information below and return it to the patient (PEIA PPB primary insured member).

Instructions for Primary Care Provider (MD, DO or NP)

1. Please indicate the results for the following measurements/tests.
2. Complete the contact information, including signature and date
3. Return completed form to patient (PPB Primary Insured).

All fields on this form are *REQUIRED*, therefore, any missing data will cause the form to be rejected.

Waist Circumference: __________ inches Blood Pressure: ________/__________

Total Cholesterol: ________________ Glucose: ____________________

Provider Contact Information

Name of Provider: ____________________ Name of Facility: ____________________

Facility Address: ____________________ Phone Number: ____________________

Medical Certification

I, ______________________________, certify that the Patient indicated above has received the measurements/results indicated on this form.

_______________________________________ ______________

(Signature of Provider or Representative of Services/Facility) ***(Date of Service)***

Please **MAIL** to beBetter Health at 6 Craddock Way, Poca, WV 25159 Attn: Rob Tuell.