



Steps to Submit Biometric Screening Data Online

For questions about the Biometric Screening Program, please email us at BiometricScreenings@bcbsal.org.

- 1 Log in to *ProviderAccess* at AlabamaBlue.com/providers. If you do not have a *ProviderAccess* user ID and password, select *Register Now*.

- 2 Under **Patient & Claim** in the main menu, select *Biometric Screening Submission*.

- 3 If not already pre-selected, choose the Business and Provider (Pharmacy) where the biometric screening is being performed.

- 4 Enter the patient's information and select *Continue*.



5 Complete the Biometric Screening Form and select *Submit*.

Home	Resources	Patient & Claim	Payment & Refund	Profiles & Reports	Search <input type="text"/>
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Business	Provider	NPI	Patient	Contract Number
Blue Pharmacy	Blue Pharmacy	0123456789	JANE DOE	ABC123456789

State Employee and Local Government Health Insurance Board Biometric Screening Form

Screening Date
12/12/2022

Does the patient have or has the patient ever been told he/she has any of the following conditions? (Mark all that apply.)

High Cholesterol High Blood Pressure Diabetes

Does the patient take medication for any of the following? (Mark all that apply.)

High Cholesterol High Blood Pressure Diabetes

Screening Data

Screening not completed due to Pregnancy or Disability? If pregnant, submit blood pressure only.

Blood Pressure	<input type="text"/> / <input type="text"/>	Blood Glucose	<input type="text"/> mg/dL
Total Cholesterol	<input type="text"/> mg/dL	Height	<input type="text"/> ft. <input type="text"/> in.
HDL Cholesterol	<input type="text"/> mg/dL	Weight	<input type="text"/>
LDL Cholesterol	<input type="text"/> mg/dL	Waist Measurement	<input type="text"/>
Triglycerides	<input type="text"/> mg/dL	Waist/Height Ratio	<input type="text"/>
		BMI	<input type="text"/>

Were any screening values abnormal?

Yes No

Was the patient referred to his/her healthcare provider for follow up?

Yes No

By signing below, I acknowledge that I have provided the patient with a copy of the applicable Employer/Health Plan sponsored Wellness Program form(s). Prior to the screening, the patient reviewed the Notice Regarding Wellness Program, confirmed that they understood the policies and procedures set out in the Notice, gave voluntary authorization to proceed with the screening, and instructed me to record their authorization herein. I further acknowledge that I counseled the patient regarding any risks associated with the screening results on this form.

Pharmacist Name

Pharmacy
BLUE PHARMACY

Pharmacy Location
123 BLUE ST.

SUBMIT



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