Diabetes Management

The form is not valid unless completely filled in and signed by the member and the provider.

Section A - Member information *(To be completed by YOU)*

First name _____ Last name _____ MI _____ Gender   M   F

Date of birth _____/_____/_____ Employer _____ PEBP ID _____
            MM   DD   YYYY

Choose one: Employee   Spouse   Child   Retiree   Domestic partner   Other dependent

Street address _____ City _____ State _____ Zip _____

Home phone _____ _____ _____ Cell _____ _____ _____ Email _____

Section B - Biometric Assessment *(MUST be completed by a CLINICIAN)*

I am currently pregnant (Check if YES)   Baby due date _____/_____/_____
                                                        MM   DD   YYYY

Total Cholesterol		Blood Pressure	
LDL (Bad) Cholesterol		Height (Inches)	
HDL (Good) Cholesterol		Weight (lbs)	
Triglyceride Level		BMI	
HgbA1C		Last eye exam	
Fast Glucose		Last dental exam	

Known Chronic Illnesses *(check all that apply)*   Diabetes   Asthma   Heart Disease   Hypertension

        Depression   Hyperlipidemia   ADHD   Other conditions _____

I, the undersigned, hereby certify that I am the named member's health care provider and I certify that I have examined the named member sufficiently to answer the above questions. Further, I certify that the above answers are true and accurate statements regarding the named member's condition.

Health care provider signature _____

Health care provider printed name _____

Section C - Signature *(To be completed by YOU)*

By signing, I authorize the disclose of my health screening results to UMR. All information released to UMR will be protected in accordance with any applicable law. I understand that information contained on this form will not be shared with my employer.

Signature _____ Date _____/_____/_____
                                           MM   DD   YYYY

How to submit: Go to **umr.com** to obtain an online version of this form. Most of Section A will fill in for you. Otherwise, print this copy and email the completed form to **diabetes@umr.com**. Questions? Call **888-763-8232**. To continue receiving the DCM enhanced benefits, a new DCM form must be completed annually, at start of the plan year. The form must be signed by both you and your physician and submitted to the third-party claims' administrator for processing.